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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green meadows, Hyatts</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San.</u>		d. STREET ADDRESS <u>6517 Seigo Parkway</u>	
3. NAME OF DECEASED (Type or print) First <u>Cleveland</u> Middle <u>(n.mn)</u> Last <u>Alsop</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-08</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Neat warehouse</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James S Alsop</u>		14. MOTHER'S MAIDEN NAME <u>Lelia E. Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>111-2-00000</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive myocardial infarction</u> (c) <u>17 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/8</u> , 19 <u>59</u> , to <u>8/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/8/59</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>High W. Irely</u> M.D. <u>7105 - Riggs Rd</u> <u>8/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ther. Hines</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Bronley</b> Last <b>AMMON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-25-02</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William L. AMMON</b>				14. MOTHER'S MAIDEN NAME <b>Nettie RIECHLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>1923 to DOD</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture dissecting aneurysm, aorta</b> <b>451x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 15</b> , 19 <b>59</b> , to <b>August 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>2:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-16-59</b>							
ACTUAL SIGNATURE <b>B. C. Johnson</b>		M.D. <b>U. S. Naval Hospital</b>					
PHYSICIAN'S NAME (Type) <b>B. C. JOHNSON, LCDR, MC, USN</b>		<b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<b>W. W. Chambers Funeral Home, 3072 M St. NW, Wash. DC</b>				<b>AUG 19 '59</b>		<b>Carlton S. Kline</b>	

Deputy Medical Examiner, Montgomery Co., notified.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

3232

Name of Deceased: William J. Brown  
 Date of Death: 1 day  
 Place of Death: Washington  
 Age: 35  
 Sex: Male  
 Race: White  
 Occupation: U. S. Navy  
 Cause of Death: Heart Disease  
 Date of Birth: 1900  
 Place of Birth: Pennsylvania  
 Signature of Physician: William J. Brown  
 Signature of Coroner: William J. Brown  
 Date of Issuance: 1935  
 Place of Issuance: Washington



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

09177

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mont Co. Gen. Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Irving Athey</b>				4. DATE OF DEATH <b>Aug. 8, 1959</b>		19	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/13/1897</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Snowden Athey</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Athey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <b>Wife</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>Aug. 8, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>8/11/59</b>		<b>Union Cemetery</b>		<b>Burtonsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Donaldson Laurel Md</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Frank J. Froese

9237

CERTIFICATE OF DEATH

Reg. Dist. No.

09178

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>5617 M e Lean Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Cecil</b> Middle <b>M</b> Last <b>Bacon</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/74</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>4</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN JOS EPH MC KEE</b>		14. MOTHER'S MAIDEN NAME <b>ANNA HAM ILTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture, Left Ventricle wall</b> (c) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>Immediate</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG 14, 1959</b> , to <b>AUG 19, 1959</b> , that I last saw the deceased alive on <b>AUG 19, 1959</b> , and that death occurred at <b>11:05 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo M. Curtis</b>		ADDRESS (Street, city or town, state) <b>8217 WISCONSIN AVE</b>	
PHYSICIAN'S NAME (Type) <b>Leo M. Curtis</b>		DATE SIGNED <b>8-19-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/22/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>	
ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Jones</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

52

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9238

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. STATE <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN lb <b>40 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>3511 Davenport St., N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Mary</b> Last <b>BAKER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-1-90</b>	
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>		IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel WELDIE</b>				14. MOTHER'S MAIDEN NAME <b>Margaret LANHAM</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>(S) R.E. Baker, 5409 Fremont St. Va.</b>				Address <b>Springfield,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>10 year</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>August 30, 1959</b> , to <b>August 30, 1959</b> that I last saw the deceased alive on <b>August 30, 1959</b> , and that death occurred at <b>11:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-31-59</b>							
ACTUAL SIGNATURE <b>G. I. Shugoll</b>				M.D. <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>G. I. SHUGOLL, LT, MC, USN Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Demaine Funeral Home, 520 S. Wash. St.</b>				24. REC'D BY REGISTRAR <b>SEP 3 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>							

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Page 4

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9339

CERTIFICATE OF DEATH

Director of Consular

Washington (Hawaii)

10 min.

Washington, D. C.

U. S. Naval Hospital

3211 Beverport St., N.Y.

Marine

Mary

BARNETT

August 20

James A. Davidson

10-1-03

28

Residence

New York

U.S.A.

Marine

Marine

Home

(2)

R. E. Barker, 2803 Belmont St., Va.

Springfield

U. S. Naval Hospital

August 20

August 20

28

August 20

U. S. Naval Hospital

C. I. Shubert, 117, MC, New Bethesda, Md.

Arlington National

Arlington, Va.

Home: General Home, 220 A. Wash. St.



## 09180

9239

**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

0233

Reg. Dist. No.

<p>1. Name of deceased: <u>John A. Bell</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>March 1, 1882</u></p>	
<p>4. Place of birth: <u>Washington, D.C.</u></p>	
<p>5. Date of death: <u>March 1, 1933</u></p>	
<p>6. Place of death: <u>Washington, D.C.</u></p>	
<p>7. Cause of death: <u>Heart failure</u></p>	
<p>8. Duration of illness: <u>2 days</u></p>	
<p>9. Name of attending physician: <u>Dr. J. A. Bell</u></p>	
<p>10. Name of medical examiner: <u>Dr. J. A. Bell</u></p>	
<p>11. Name of funeral home: <u>None</u></p>	
<p>12. Name of next of kin: <u>None</u></p>	
<p>13. Name of informant: <u>None</u></p>	
<p>14. Signature of registrar: <u>[Signature]</u></p>	
<p>15. Date of registration: <u>March 1, 1933</u></p>	

Vertical text on the right margin, possibly a date or reference number.

Small circular stamp or mark on the right margin.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09181

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwood - rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwood - rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #1</u>				d. STREET ADDRESS <u>R.F.D. #1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Williams Floyd Ballenger</u>				4. DATE OF DEATH Month Day Year <u>Aug 19 19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Us</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Wm H. Ballenger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Coffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>1925 1928 579 44 1570</u>		17. INFORMANT <u>Edna Ballenger (wife)</u> Address <u>Strom 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound in rt temple</u> DUE TO (c) <u>Sudden</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound in rt temple</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>8-19 19 59</u> P. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) <u>Berwood</u> (County) <u>Monty</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 22 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lake View</u>		22d. LOCATION (City, town, or county) <u>Hamilton</u> (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u> ADDRESS <u>Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Chas E. Kane</u>	



9241

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Miriam G Bartlett</b>				4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 16 1869</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Mass.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James O. Bartlett</b>				14. MOTHER'S MAIDEN NAME <b>Olive Little Rogers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miriam Hoffman - Item #2- niece</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 Hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>parkinsonism, Bronchopneumonia</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>Aug 14</b> , 19 <b>59</b> to <b>August 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 26</b> , 19 <b>59</b> , and that death occurred at <b>6:40 a</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b> M.D.				ADDRESS (Street, city or town, state) <b>10609 Concord Street</b>			
DATE SIGNED <b>August 27, 1959</b>							
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b> <b>Kensington, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL, SPECIFY <b>Cremation</b>		22b. DATE THEREOF <b>8/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>AUG 28 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Christina S. Hines</b>							







**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9242**  
**CERTIFICATE OF DEATH**

09183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>Beall</b>				4. DATE OF DEATH Month <b>8.28.</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9.29.1872</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.		IF UNDER 24 HRS. Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. Road Department (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>(Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John Thomas Beall</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Whitey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Apoplexy, thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>331X</b> DUE TO (c) <b>331X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>331X</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/25</b> , 19 <b>55</b> , to <b>8/28</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8/28</b> , 19 <b>55</b> , and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b> DATE SIGNED <b>8.28.59</b>							
ACTUAL SIGNATURE <b>[Signature]</b> M.D.							
PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial Aug 31, 1959</b>		<b>Aug 31, 1959</b>		<b>Union Cemetery</b>		<b>Burtonsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>De Witt Canaleham Laurel Md</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9232

Name of Deceased		John Thomas Smith	
Sex		Male	
Age		45	
Date of Birth		1885	
Place of Birth		Maryland	
Cause of Death		Heart Disease	
Date of Death		1932	
Place of Death		Home	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Signature of Coroner		[Signature]	
Signature of Burial Officer		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Minister		[Signature]	
Signature of Family		[Signature]	
Signature of Friends		[Signature]	
Signature of Neighbors		[Signature]	
Signature of Community		[Signature]	
Signature of Church		[Signature]	
Signature of School		[Signature]	
Signature of Business		[Signature]	
Signature of Government		[Signature]	
Signature of Other		[Signature]	

9243

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09184

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. STREET ADDRESS <b>215 Northway Gifford</b>	
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>Elizabeth</b> Last <b>Beck</b>		4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1.20.1873</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Luther Scott Clagett</b>		14. MOTHER'S MAIDEN NAME <b>France Sarah Ryan Ford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy, Thrombotic</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerosis</b> DUE TO (c) <b>Chronic myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>10 yrs</b> <b>15 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>8/12</b> , 19 <b>55</b> , to <b>8/18</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>8/18</b> , 19 <b>55</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Sandy Spring, Md.</b>		DATE SIGNED <b>8/18/55</b>
PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M. D.,</b>		<b>8.18.59</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	22b. DATE THEREOF <b>8/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Maus.</b>
22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
9244											
CERTIFICATE OF DEATH											
Reg. Dist. No. 09185 215											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>7105 CLARENDON ROAD</b>						
3. NAME OF DECEASED (Type or print) First <b>Kevin</b> Middle <b>Wayne</b> Last <b>BENNETT</b>					4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 59</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-1-59</b>		9. AGE (In years last birthday) yrs. <b>8</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b> Hours <b>8</b> Min. <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Buddy Lee BENNETT</b>					14. MOTHER'S MAIDEN NAME <b>Barbara Ruth JONES</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Hospital Records</b>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>340.3</b> <b>Meningitis acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>August 1</b> , 19 <b>59</b> , to <b>August 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 9</b> , 19 <b>59</b> , and that death occurred at <b>8:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda, Md.</b> DATE SIGNED <b>8-10-59</b> ACTUAL SIGNATURE <b>[Signature]</b> PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>			22b. DATE THEREOF <b>8-11-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Butler, Mo. MISSOURI</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b> ADDRESS <b>R.A. Humphrey Funeral Home, Bethesda, Md.</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

2051221XV3





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
9245<sup>cc</sup> MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

Reg. Dist. No.

09186

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>3418 Minnesota Avenue, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Willis Stokes Booth</b>				4. DATE OF DEATH Month Day Year <b>August 9, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 3, 1899</b>	
9. AGE (In years lost birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Streetcar motorman</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Booth</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Collie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the Larynx</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 year</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 28, 1959</b> to <b>August 9, 1959</b> , that I last saw the deceased alive on <b>August 9, 1959</b> , and that death occurred at <b>2:05 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard S. Schwartz</i> PHYSICIAN'S NAME (Type) <b>Howard S. Schwartz, M. D.</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>8-9-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Bladensburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i> ADDRESS <b>517 11th St. S.E.</b>				24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

DATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		New York City		10:00 AM		[Signature]		[Signature]	
Occupation		Marital Status		Education		Religion		Race		Color		Manner of Death		Medical History		Post-mortem Exam		Burial Place		Burial Date	
Teacher		Married		High School		Catholic		White		White		Natural		None		No		Catholic Cemetery		Jan 15, 1945	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death	
Jan 10, 1945		10:00 AM		New York City		Heart Disease		New York City		10:00 AM		[Signature]		[Signature]		Jan 10, 1945		10:00 AM		New York City	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
9246														
CERTIFICATE OF DEATH														
Reg. Dist. No. 215														
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>East Point</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>49X-3</b> d. STREET ADDRESS <b>1395 Virginia Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>Michael Phillip BOYNTON</b>					4. DATE OF DEATH Month Day Year <b>August 11 19 59</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-25-58</b>		9. AGE (In years last birthday) <b>1</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Jack D. BOYNTON</b>					14. MOTHER'S MAIDEN NAME <b>Faye S. CRUSE</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					INFORMANT <b>(F) Jack D. Boynton, same as #2 above</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atrio-ventricular canal</b> 7542 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>from birth</b>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 10</b> , 19 <b>59</b> , to <b>August 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 11</b> , 19 <b>59</b> , and that death occurred at <b>5:55 PM</b> , from the causes on and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>U. S. Naval Hospital</b> <b>8-12-59</b> PHYSICIAN'S NAME (Type) <b>G. I. SHUGOLL, LT, MC, USN</b> <b>Bethesda, Maryland</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>			22b. DATE THEREOF <b>8-12-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>College Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>College Park Georgia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumpfrey</b> ADDRESS <b>Pumpfrey Funeral Home, Bethesda, Md.</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

9246

CENTRE OF GRAVITY

9218

U. S. Naval Hospital  
395 Virginia Ave.  
Norfolk, Va.  
George  
East Point  
1 day  
State  
Constitution  
1-15-57  
Hon  
John  
Joe D. BOYNTON  
1908 E. CHURCH  
New York  
Joe D. BOYNTON, born in New York  
1908 E. CHURCH  
New York  
1908 E. CHURCH  
New York



U. S. Naval Hospital  
395 Virginia Ave.  
Norfolk, Va.  
George  
East Point  
1 day  
State  
Constitution  
1-15-57  
Hon  
John  
Joe D. BOYNTON  
1908 E. CHURCH  
New York  
Joe D. BOYNTON, born in New York  
1908 E. CHURCH  
New York  
1908 E. CHURCH  
New York

9247

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7514 Radnor Rd.</b>				e. STREET ADDRESS <b>7514 Radnor Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JESSIE</b> Middle <b>MAY</b> Last <b>BRADFORD</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>28,</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1867</b>		9. AGE (In years last birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John W. Comalander</b>				14. MOTHER'S MAIDEN NAME <b>Jamaima Cortez</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Son.</b> <b>ROBERT BRADFORD</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <b>Congestive Heart Failure</b> (c) <b>Rheumatic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 months</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 14, 1959</b> to <b>Aug. 28, 1959</b> , that I last saw the deceased alive on <b>Aug. 26, 1959</b> , and that death occurred at <b>7:00A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jack P. Segal</b>				ADDRESS (Street, city or town, state) <b>900-17th Street, N. W.</b>			
DATE SIGNED <b>8-28-59</b>							
PHYSICIAN'S NAME (Type) <b>JACK P. SEGAL, MD.</b>				Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9247

WILLIAM STATE DEPARTMENT OF HEALTH - BUREAU OF  
MONTGOMERY, MARYLAND  
JESSIE M/T BRADY  
FAMOUS WHITE  
ALABAMA  
JAMES  
ROBERT  
SOME AS FROM 42

BRONCHO PNEUMONIA  
CONGESTIVE HEART FAILURE  
RHEUMATIC HEART DISEASE  
Aug. 20, 1932  
900-17th Street, N.W.  
Washington, D.C.  
6-21-32  
Robert A. Humphrey, M.D.  
John A. Smith, M.D.



9248

## CERTIFICATE OF DEATH

09189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN Hosp.</u>		d. STREET ADDRESS <u>5637 Western Ave</u>	
3. NAME OF DECEASED (Type or print) a. First <u>William Young</u> Middle <u>BRADY</u> Last <u>BRADY</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/1889</u>
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Architectural Eng</u>	
11. BIRTHPLACE (State or foreign country) <u>FRANKLIN, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES BRADY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET M. YOUNG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> INFORMANT Address <u>Miss Louise BRADY - (daughter)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Respiratory Circulatory Failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Accident.</u> DUE TO (c) <u>Generalized Arteriosclerosis.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia - Basilar</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/27</u> , 19 <u>59</u> , to <u>8/14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/13</u> , 19 <u>59</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Q Elsmen</u> M.D. <u>5707 Wisconsin Ave.</u>		ADDRESS (Street, city or town, state) <u>Chesapeake Md.</u> DATE SIGNED <u>8/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Donald Q Elsmen</u>		5757 Wisc. Ave. Chevy Chase, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 18 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2248

OFFICE OF CLERK

IN THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1914

Received of the  
Baltimore Board of Health  
the sum of \$10.00  
for the year 1914

8/13  
1914  
Baltimore Board of Health  
Baltimore, Md.

8/13/14

1914

9249

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>3303 Fayette Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Lambert Brown</b>			4. DATE OF DEATH Month Day Year <b>August 1, 19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1904</b>		9. AGE (In years lost birthday) <b>54</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supply Drug Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Charles L. Brown</b>		
14. MOTHER'S MAIDEN NAME <b>ERMA L. Gaither</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>577-07-6317</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septointestinal bleeding, esophageal</b> <b>581.0</b> DUE TO <b>varices</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the liver</b> DUE TO (c) <b>hemochromatosis</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>July 30, 19 59</b> , to <b>August 1, 19 59</b> , that I last saw the deceased alive on <b>August 1, 19 59</b> , and that death occurred at <b>8:05 P</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Alfred Leitner</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>8-2-59</b>	
PHYSICIAN'S NAME (Type) <b>Alfred Leitner, M. D.</b>		NATIONAL INSTITUTES OF HEALTH <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>IVY HILL CEMETERY</b>	
22d. LOCATION (City, town, or county) <b>UPPERVILLE, VIRGINIA</b>		22e. (State) <b>(State)</b>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Zisk</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>Aug 4 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Francis</b>		DATE <b>Aug 4 59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9250  
CERTIFICATE OF DEATH

09191

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>26 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>62 X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mexico</b> d. STREET ADDRESS <b>RFD #4</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Leslie Holmer BULL</b>			4. DATE OF DEATH Month Day Year <b>August 22 19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-96</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John BULL</b>			14. MOTHER'S MAIDEN NAME <b>Nellie DEBO</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>5/17 to 9/19 Unknown</b>		INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarct</b> (c) <b>Coronary occlusion</b> <b>Coronary Atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval BETWEEN ONSET AND DEATH</b> <b>Seconds?</b> <b>3 years</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(County) (State)</b>	
21. I certify that I attended the deceased from <b>July 27</b> , 19 <b>59</b> , to <b>August 22</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 21</b> , 19 <b>59</b> , and that death occurred at <b>6:35 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-22-59</b> ACTUAL SIGNATURE <b>F. H. O'Connell</b> M.D. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LCDR, MC, USN Bethesda, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) <b>Arlington</b>		22e. (State) <b>Virginia</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9251

## CERTIFICATE OF DEATH

Reg. Dist. No.

09192

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>97 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83X-3</b> d. STREET ADDRESS <b>714 Manor Road, Apt. # 303</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eleanor</b> Middle <b>Josephine</b> Last <b>Burke</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1927</b>
9. AGE (In years last birthday) <b>32</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Press Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Steve Yenko</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Koss</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>206-22-1718</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins' Disease</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cryptococcosis</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>25 May</b> , 19 <b>59</b> , to <b>30 August</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>30 August</b> , 19 <b>59</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Harold J. Fallon</b> M.D. <b>The Clinical Center</b> <b>8/31/59</b> PHYSICIAN'S NAME (Type) <b>Harold J. Fallon, M. D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>		22b. DATE THEREOF <b>9/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Lourdes</b>		22d. LOCATION (City, town, or county) (State) <b>Robinson Township, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b> DATE <b>SEP 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

CERTIFICATE OF DEATH

REG. NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

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MADE IN U.S.A.  
FAMILY BOARD

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09193

Reg. Dist. No.

9252

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthland R-1</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garthland R-1</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wayfield Rd</u>				1d. STREET ADDRESS <u>Wayfield Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Albert James Butler</u>				4. DATE OF DEATH <u>Aug 9 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-16-1908</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>John Butler</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Beul Brather</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Hilda Butler (wife)</u> Address <u>Stim 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left lung with</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>metastasis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Blaschke</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BLASCHKE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/12/59</u>		<u>Brooke Grove,</u>		<u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Suroder</u>				ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
				24a. REC'D BY REGISTRAR DATE <u>AUG 12 '59</u>			

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FOR STATE  
HEALTH DEPT.

9252

NEW YORK STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. EDUCATION <i>High School</i>	
9. RELIGION <i>Catholic</i>		10. RACE <i>White</i>	
11. CAUSE OF DEATH <i>Heart Disease</i>			
12. MANNER OF DEATH <i>Natural</i>			
13. SIGNATURE OF EXAMINER <i>Dr. J. Smith</i>			
14. DATE OF EXAMINATION <i>Jan 20 1945</i>			
15. PLACE OF EXAMINATION <i>New York City</i>			
16. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>			
17. DATE OF DEATH <i>Jan 18 1945</i>			
18. PLACE OF DEATH <i>New York City</i>			
19. SIGNATURE OF FUNERAL HOME <i>Funeral Home</i>			
20. DATE OF BURIAL <i>Jan 22 1945</i>			
21. PLACE OF BURIAL <i>Catholic Cemetery</i>			
22. SIGNATURE OF CLERGYMAN <i>Rev. J. Smith</i>			
23. DATE OF INTERMENT <i>Jan 22 1945</i>			
24. PLACE OF INTERMENT <i>Catholic Cemetery</i>			
25. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
26. DATE OF CREMATION <i>Jan 22 1945</i>			
27. PLACE OF CREMATION <i>Catholic Cemetery</i>			
28. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
29. DATE OF BURIAL <i>Jan 22 1945</i>			
30. PLACE OF BURIAL <i>Catholic Cemetery</i>			
31. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
32. DATE OF CREMATION <i>Jan 22 1945</i>			
33. PLACE OF CREMATION <i>Catholic Cemetery</i>			
34. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
35. DATE OF BURIAL <i>Jan 22 1945</i>			
36. PLACE OF BURIAL <i>Catholic Cemetery</i>			
37. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
38. DATE OF CREMATION <i>Jan 22 1945</i>			
39. PLACE OF CREMATION <i>Catholic Cemetery</i>			
40. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
41. DATE OF BURIAL <i>Jan 22 1945</i>			
42. PLACE OF BURIAL <i>Catholic Cemetery</i>			
43. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
44. DATE OF CREMATION <i>Jan 22 1945</i>			
45. PLACE OF CREMATION <i>Catholic Cemetery</i>			
46. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
47. DATE OF BURIAL <i>Jan 22 1945</i>			
48. PLACE OF BURIAL <i>Catholic Cemetery</i>			
49. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
50. DATE OF CREMATION <i>Jan 22 1945</i>			
51. PLACE OF CREMATION <i>Catholic Cemetery</i>			
52. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
53. DATE OF BURIAL <i>Jan 22 1945</i>			
54. PLACE OF BURIAL <i>Catholic Cemetery</i>			
55. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
56. DATE OF CREMATION <i>Jan 22 1945</i>			
57. PLACE OF CREMATION <i>Catholic Cemetery</i>			
58. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
59. DATE OF BURIAL <i>Jan 22 1945</i>			
60. PLACE OF BURIAL <i>Catholic Cemetery</i>			
61. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
62. DATE OF CREMATION <i>Jan 22 1945</i>			
63. PLACE OF CREMATION <i>Catholic Cemetery</i>			
64. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
65. DATE OF BURIAL <i>Jan 22 1945</i>			
66. PLACE OF BURIAL <i>Catholic Cemetery</i>			
67. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
68. DATE OF CREMATION <i>Jan 22 1945</i>			
69. PLACE OF CREMATION <i>Catholic Cemetery</i>			
70. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
71. DATE OF BURIAL <i>Jan 22 1945</i>			
72. PLACE OF BURIAL <i>Catholic Cemetery</i>			
73. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
74. DATE OF CREMATION <i>Jan 22 1945</i>			
75. PLACE OF CREMATION <i>Catholic Cemetery</i>			
76. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
77. DATE OF BURIAL <i>Jan 22 1945</i>			
78. PLACE OF BURIAL <i>Catholic Cemetery</i>			
79. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
80. DATE OF CREMATION <i>Jan 22 1945</i>			
81. PLACE OF CREMATION <i>Catholic Cemetery</i>			
82. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
83. DATE OF BURIAL <i>Jan 22 1945</i>			
84. PLACE OF BURIAL <i>Catholic Cemetery</i>			
85. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
86. DATE OF CREMATION <i>Jan 22 1945</i>			
87. PLACE OF CREMATION <i>Catholic Cemetery</i>			
88. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
89. DATE OF BURIAL <i>Jan 22 1945</i>			
90. PLACE OF BURIAL <i>Catholic Cemetery</i>			
91. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
92. DATE OF CREMATION <i>Jan 22 1945</i>			
93. PLACE OF CREMATION <i>Catholic Cemetery</i>			
94. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
95. DATE OF BURIAL <i>Jan 22 1945</i>			
96. PLACE OF BURIAL <i>Catholic Cemetery</i>			
97. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			
98. DATE OF CREMATION <i>Jan 22 1945</i>			
99. PLACE OF CREMATION <i>Catholic Cemetery</i>			
100. SIGNATURE OF MINISTER <i>Rev. J. Smith</i>			

9253

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>22 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Derwood</b> d. STREET ADDRESS <b>Rt. #1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Cora Lee Butt</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 59</b>		5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2/13/90</b>		9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Private nursing care</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Edwin Shaw</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Sullivan</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>577-01-9250</b>				17. INFORMANT <b>Hospital Records</b> Address <b>Olney, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171X Carcinomatosis, generalized</b> DUE TO (b) <b>Adenocarcinoma of Cervix Uteri</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 mo</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>															
MEDICAL CERTIFICATION															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 15, 1959</b> , to <b>8/3, 1959</b> , that I last saw the deceased alive on <b>8/2, 1959</b> , and that death occurred at <b>1:55 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b> DATE SIGNED <b>Arthur S. Hines</b>															
ACTUAL SIGNATURE <b>C. H. Ligon, M.D.</b>				PHYSICIAN'S NAME (Type) <b>C. H. Ligon, M.D.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>8/6/59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Colesville Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Colesville, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, Inc., Silver Spring, Md.</b> <b>Raymond A. Ziska</b>				24a. REC'D BY REGISTRAR <b>DATE AUG 5 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







9254

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>NEW YORK</b> b. COUNTY <b>New York</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW YORK</b> <b>69x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8800 MELWOOD ROAD</b>		d. STREET ADDRESS <b>124 W. 47TH ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>PAUL</b> Last <b>CARROLL</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 9, 1895</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PUBLIC RELATIONS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ENTERTAINMENT</b>	
11. BIRTHPLACE (State or foreign country) <b>EIRE</b>		12. CITIZEN OF WHAT COUNTRY? <b>EIRE</b> ✓	
13. FATHER'S NAME <b>JOHN CARROLL</b>		14. MOTHER'S MAIDEN NAME <b>ANNE WELCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>077-01-2340</b>	
17. INFORMANT <b>LA. PYLE, JR. MD</b>		Address <b>8800 MELWOOD RD BETHESDA 14, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure (obstructive)</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchogenic carcinoma (at least)</b> DUE TO (c) <b>3 months</b> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 9, 1959</b> , to <b>death</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8-13-59</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>MARCEL J FORET</b> M.D.		ADDRESS (Street, city or town, state) <b>1746 K St N.W. Washington 6 D.C.</b> DATE SIGNED <b>8/13/59</b>	
PHYSICIAN'S NAME (Type) <b>MARCEL J FORET</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>8/13/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Md</b>	
24a. REC'D BY REGISTRAR <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9205

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>7 1/2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp. Tal</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Anna Charukas</u>		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-19-29</u>
9. AGE (In years last birthday) <u>30</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Stavros</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u> 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of skull</u> (c) <u>Struck by auto</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 1/2 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pedestrian crossing street</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by auto while crossing street</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5:31</u> p.m. <u>8-15</u> 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>727 W. Blvd E</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Kins Co</u>		24a. REC'D BY REGISTRAR <u>28101-14th St NW</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		24c. DATE <u>AUG 18 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2202

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various administrative stamps.]*

FOR STATE  
HEALTH DEPT.

9255

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6923 Clarendon Road</b>				d. STREET ADDRESS <b>6923 Clarendon Road</b>	
3. NAME OF DECEASED (Type or print) First <b>NEWELL</b> Middle <b>D.</b> Last <b>CHASE</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>10,</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1871</b>		9. AGE (In years last birthday) <b>88 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Engr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			13. FATHER'S NAME <b>Hanibal Chase</b>		
14. MOTHER'S MAIDEN NAME <b>Rebecca Newell</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT Address <b>Mrs. Nina R. Chase, 6923 Clarendon Rd.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.1 Acute Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Aricular fabrillation</b> (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found dead in bed Months</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed Months</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>August 10, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>8/10/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Maryland</b>			24a. REC'D BY REGISTRAR <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clifton S. Frank</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



10

10. *Chlorophyll a* and *Chlorophyll b* content of the leaves was determined by the method of Arnon (1949).



1  
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X  
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2  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09198

9229

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>812 Grandin Avenue</b>		d. STREET ADDRESS <b>812 Grandin Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GRACE COLLONS CLAGETT</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>11,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/15</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Potomac, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Collins</b>		14. MOTHER'S MAIDEN NAME <b>Eliz. Claggett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daughter - Rose Lee Claggett</b>		Address <b>812 Grandin Avenue Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism Due Thrombophlebitis</b> <b>332X</b> DUE TO <b>Right Leg</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Infarction</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 weeks</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 49</b> , 19____, to <b>11 Aug.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10 Aug.</b> , 19 <b>59</b> , and that death occurred at <b>8 A.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.S. Murphy</b>		M.D. <b>615 W. Montgomery Ave. Rockville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. S. Murphy</b>		ADDRESS (Street, city or town, state) <b>615 W. Montgomery Ave., Rockville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lyon Walker Rockville, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>AUG 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. King</b>	

2352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9256

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09199

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>88 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Saint Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Roach</b> Last <b>Clarke</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner of Concrete Company Concrete</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Garland Clarke</b>		14. MOTHER'S MAIDEN NAME <b>Celeste Roach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myelocytic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3</b> , 19 <b>59</b> , to <b>August 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 30</b> , 19 <b>59</b> , and that death occurred at <b>2:15 A</b> .M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/30/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's</b>		22d. LOCATION (City, town, or county) (State) <b>Ridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarle Mattingley Leonardtown, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

CERTIFICATE OF DEATH

3272

DATE OF DEATH		PLACE OF DEATH	
August 22, 1922		Home	
AGE		SEX	
60 years		Male	
RACE		RELIGION	
White		Roman Catholic	
MARRIAGE		EDUCATION	
Married		High School	
OCCUPATION		SOURCES OF INCOME	
None		None	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Failure		Natural	
DISEASE		SYMPTOMS	
None		None	
PREVIOUS ILLNESS		TREATMENT	
None		None	
DATE OF BIRTH		PLACE OF BIRTH	
August 1, 1862		Maryland	
FATHER'S NAME		MOTHER'S NAME	
John J. Smith		Mary J. Smith	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
None		None	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
Maryland		Maryland	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
None		None	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
None		None	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
None		None	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
None		None	
FATHER'S PREVIOUS ILLNESS		MOTHER'S PREVIOUS ILLNESS	
None		None	
FATHER'S TREATMENT		MOTHER'S TREATMENT	
None		None	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
None		None	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
None		None	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH	
None		None	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
None		None	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH	
None		None	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
None		None	
FATHER'S PREVIOUS ILLNESS		MOTHER'S PREVIOUS ILLNESS	
None		None	
FATHER'S TREATMENT		MOTHER'S TREATMENT	
None		None	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 5/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09200

9257

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Route 2 Box 110</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Virginia</u> Last <u>Clipper</u>		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 7, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Washington</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Same - daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus &amp; Acidosis</u> DUE TO (c) <u>Arteriosclerotic Cardio-vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro-vascular Accident</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Rosenberg</u> M.D.		ADDRESS (Street, city or town, state) <u>26 N. Summit Ave. City 1959</u>	
DATE SIGNED <u>9/10/59</u>		DATE SIGNED <u>9/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Seneca</u>		22d. LOCATION (City, town, or county) (State) <u>Seneca, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	



1874

CERTIFICATE OF DEATH

1874

Female C. 1874  
Hennrichs  
Hennrichs  
Mrs. John B. Hennrichs  
Virginia  
March 1874  
1874





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

9258

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7721 Eastern Ave</u>		d. STREET ADDRESS <u>7721 Eastern Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Lloyd Phillip Coblentz</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-06</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>delivery man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pickens X'say</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph D. Coblentz</u>		14. MOTHER'S MAIDEN NAME <u>Lillian B. Shalkop</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> WW #2		16. SOCIAL SECURITY NO. <u>578-24-4921</u>	
17. INFORMANT <u>Mrs. Lillian J. Poole, 111 Wayne Place, S.E.</u>		Address <u>Washington, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-25-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>DAUG 31 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9259

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09202

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47x-3</b>		d. STREET ADDRESS <b>2500 Q. Street N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>M ARIE</b> Middle <b>T.</b> Last <b>COFFIN</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>18</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/6/92</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>MARSHALL THRAILKILL</b>		14. MOTHER'S MAIDEN NAME <b>LAURA HAUGHN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>MR. Thad Brown (Son)</b>		Address <b>Washington 16, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>155.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Carcinoma of Gall Bladder</b> DUE TO (c) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Aug</b> , 19 <b>59</b> , to <b>18 Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>18 Aug</b> , 19 <b>59</b> , and that death occurred at <b>2054</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>615 W. Main St. Rockville, Md.</b> DATE SIGNED <b>18 Aug 1959</b>			
ACTUAL SIGNATURE <b>W. S. MURPHY</b>		PHYSICIAN'S NAME (Type) <b>W. S. MURPHY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Columbus, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler Jr.</b>		ADDRESS <b>1756 Pa. Ave., N.W. DC</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>	

3553

CERTIFICATE OF DEATH

STATE OF OHIO  
COUNTY OF COLUMBIA  
I, JAMES H. HARRIS, M.D., of the County of Columbia, State of Ohio, do hereby certify that on the 1st day of January, 1901, at the City of Cincinnati, Ohio, died \_\_\_\_\_, of the County of \_\_\_\_\_, State of \_\_\_\_\_, who was \_\_\_\_\_ years of age, \_\_\_\_\_ sex, \_\_\_\_\_ color, \_\_\_\_\_ marital status, and \_\_\_\_\_ occupation, who was \_\_\_\_\_ at the time of death, and who died of \_\_\_\_\_, and that the death was \_\_\_\_\_.

1

Witness my hand and the seal of my office this \_\_\_\_\_ day of \_\_\_\_\_, 1901.  
JAMES H. HARRIS, M.D.  
City of Cincinnati, Ohio.

W. L. HARRIS, M.D.  
City of Cincinnati, Ohio.  
JAMES H. HARRIS, M.D.  
City of Cincinnati, Ohio.



*[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9261

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09204

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MAPLE LANE NURSING HOME</b>		d. STREET ADDRESS <b>902 HERON DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Josephine</b> Last <b>CONROY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/77</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>TUAM COUNTY, IRELAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS LOFTUS</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Martin J. Conroy, 902 Heron Dr.</b>		Address <b>Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE HEART DISEASE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ESSENTIAL HYPERTENSION</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 22</b> , 19 <b>58</b> , to <b>Aug. 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 17</b> , 19 <b>59</b> , and that death occurred at <b>2:22</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5206 Narwood Dr.</b> DATE SIGNED ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D. PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MADONNA CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FORT LEE, NEW JERSEY</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knorr</b>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. DATE OF BIRTH                  [REDACTED]</p>	
<p>5. PLACE OF BIRTH                  [REDACTED]</p>		<p>6. OCCUPATION                  [REDACTED]</p>	
<p>7. MARITAL STATUS                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>	
<p>9. MEDICAL HISTORY                  [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>	
<p>11. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>15. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>17. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>19. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>21. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>23. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>25. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>27. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>29. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>31. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>33. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>35. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>37. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>39. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>41. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>43. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>45. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>47. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>49. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>51. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>53. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>55. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>57. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>58. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>59. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>61. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>63. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>65. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>67. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>69. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>71. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>73. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>75. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>77. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>79. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>81. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>83. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>85. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>87. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>89. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>91. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>93. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>95. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>97. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>99. SIGNATURE OF DECEASED                  [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS                  [REDACTED]</p>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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X

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AP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09205
9262										
CERTIFICATE OF DEATH										
										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>					c. LENGTH OF STAY IN 1b <b>56 Silver Spring</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9704 ADMIRALTY DRIVE</b>					1. STREET ADDRESS <b>9704 Admiralty Drive</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WINIFRED</b> Middle <b>H.S.</b> Last <b>COOKSON</b>					4. DATE OF DEATH Month <b>8</b> Day <b>16</b> Year <b>19 59</b>					
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/25/76</b>		9. AGE (In years lost birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maine</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>---Stone</b>					14. MOTHER'S MAIDEN NAME <b>---Harper</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT <b>Ione Slothower</b> Address <b>same as #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, uterus &amp; metastases</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO									INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive heart failure</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1956</b> to <b>Aug 16, 1959</b> , that I last saw the deceased alive on <b>Aug 15, 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10111 COLESVILLE RD</b> DATE SIGNED ACTUAL SIGNATURE <b>A. F. Thibadeau</b> M.D. PHYSICIAN'S NAME (Type) <b>A. F. THIBADEAU</b> <b>SILVER SPRING, MD</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			22b. DATE THEREOF <b>8/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9263

## CERTIFICATE OF DEATH

09206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>6720 North 25th Street</b>		
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Luther</b> Last <b>Copley</b>			4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1905</b>		9. AGE (In years lost birthday) <b>53</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Moses Copley</b>			14. MOTHER'S MAIDEN NAME <b>Emma Lambert</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-05-6953</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Granulocytic Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X Pulmonary Tuberculosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>March 23, 1959</b> , to <b>August 12, 1959</b> , that I last saw the deceased alive on <b>August 12, 1959</b> , and that death occurred at <b>12:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/12/59</b> ACTUAL SIGNATURE <b>Richard C. Mechanic</b> M.D. <b>The Clinical Center</b> PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 14, 1959</b>		22c. NAME OF CEMETERY OR CREMATOR <b>Wash. National</b>	
22d. LOCATION (City, town, or county) <b>Pt. Geo. Co., Md.</b>		22e. (State) <b>Md.</b>		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chamberlin Co.</b>		23a. ADDRESS <b>1400 Chapin St. N.W., Wash., D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3255

Name of Deceased William J. ...		Date of Birth ...	
Sex Male		Race White	
Usual Residence ...		Place of Death ...	
Date of Death ...		Time of Death ...	
Cause of Death ...		Manner of Death ...	
Physician ...		Burial Place ...	
Registrar ...		Date of Registration ...	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

9264

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>14 Wessex Rd</u>		d. STREET ADDRESS <u>14 Wessex Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Leslie</u> Last <u>Cranford</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>7-7-1902</u>	
8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical Supply Co</u>	
11. BIRTHPLACE (State or foreign country) <u>S. Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Cranford</u>		14. MOTHER'S MAIDEN NAME <u>Annie Williamson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #2</u>	
17. INFORMANT <u>Mary Cranford</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage + laceration</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound in skull</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>8-27</u> 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Silver Spring Monty Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-27-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		ADDRESS <u>Washington, D. C.</u>	
24a. REC'D BY REGISTRAR <u>AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9265

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>75 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2523 Palmer Place, S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Courtney</b> Last <b>Custer</b>		4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>19 59</b>									
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1921</b>	9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photo Engraver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Business Machines</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Joseph Custer</b>		14. MOTHER'S MAIDEN NAME <b>ELSIE Jessie Jones</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>577-28-8070</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage from lung into trachea &amp; bronchi</b> 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Teratocarcinoma of testes with metastasis to lungs</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5-10 min.</b> <b>4 yrs.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>May 19 59</b> to <b>August 2 59</b> , that I last saw the deceased alive on <b>August 2 1959</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>		DATE SIGNED <b>8-2-59</b>		
ACTUAL SIGNATURE <b>L. A. Gaydos</b>		M.D. <b>Lawrence A. Gaydos, M. D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) <b>Bladensburg, Maryland</b>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Washington, D.C.</b>							ADDRESS <b>Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

Name of deceased		Sex		Age	
The National Center, Baltimore, Md.		Male		35	
Place of birth		Date of birth		Place of death	
Baltimore, Md.		Jan 1, 1900		Baltimore, Md.	
Cause of death		Date of death		Place of death	
Pneumonia		Jan 1, 1935		Baltimore, Md.	
Occupation		Marital status		Education	
Physician		Single		High School	
The National Center, Baltimore, Md.		Never married		The National Center, Baltimore, Md.	
Signature of physician		Signature of registrar		Signature of witness	
[Signature]		[Signature]		[Signature]	
Date of death		Date of registration		Date of filing	
Jan 1, 1935		Jan 1, 1935		Jan 1, 1935	

9230

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 ROCKVILLE</b>			
c. LENGTH OF STAY IN 1b <b>27 years</b>				d. STREET ADDRESS <b>14,712 GEORGIA AVENUE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>14,712 GEORGIA AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>RYAN</b> Last <b>DAILY</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>19 59</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/97</b>		9. AGE (In years lost birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY-AT-LAW</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>WELSH, DAILY &amp; WELSH</b>			11. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JOHN RYAN</b>				
14. MOTHER'S MAIDEN NAME <b>MARGARET DAILY</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW #2</b>				
16. SOCIAL SECURITY NO. <b>yes</b>			17. INFORMANT Address <b>Mrs. Florence T. Daily, 14712 Ga. Ave.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer metastasis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Stomach</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>18 mos</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>7/1/58</b> to <b>8/1/59</b> , that I last saw the deceased alive on <b>8/9/59</b> , 19 <b>59</b> , and that death occurred at <b>10 P M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. W. BIRD</b>				ADDRESS (Street, city or town, state) <b>Sandy Spring, Md</b>			
PHYSICIAN'S NAME (Type) <b>J. W. BIRD</b>				DATE SIGNED <b>8/11/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond H. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9266

## CERTIFICATE OF DEATH

Reg. Dist. No.

09210

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5318 Bangor Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>FRANCIS</b> Last <b>DANEHY</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>13,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1909</b>
9. AGE (In years lost birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>14</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John G. Danehy</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Flynn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mary S. Danehy - Wife - Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>154X</b> DUE TO <b>Carcinoma of rectum</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO <b></b> (c) DUE TO <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10 Aug, 1959</b> to <b>13 Aug 1959</b> , that I last saw the deceased alive on <b>12 Aug, 1959</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Vincent M. Iovine</b> M.D. <b>1150 Connecticut Avenue, N.W. Washington, D.C.</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>VINCENT M. IOVINE, M.D.</b> <b>1150 Connecticut Avenue, N.W. Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-17-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

02310

2266

CERTIFICATE OF DEATH

Non-Resident

Deceased's Name

3118 Sanjour Drive

THOMAS

REAR

WORTH

Aug. 17

22

Male

White

July 20, 1904

Residence

John A. Dineen

WM 11

Wm 11

Wm 11 - Wm 11 - Wm 11

Wm 11 - Wm 11 - Wm 11

Wm 11 - Wm 11 - Wm 11

22

Wm 11 - Wm 11 - Wm 11

Wm 11 - Wm 11 - Wm 11

Wm 11 - Wm 11 - Wm 11

Wm 11 - Wm 11 - Wm 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A13 (4)  
15M 9/55

9267

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09211

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>121 Deer Park Drive</b>		d. STREET ADDRESS <b>121 Deer Park Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES WILLIAM DARNELL</b>		4. DATE OF DEATH Month Day Year <b>August 6, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1883</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>7 29</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harvey Darnell</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Cox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Alice Suddueth-123 Deer Park Dr.-Gaithersburg, Md</b>		Address <b>Daughter</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PREVIOUS CEREBRAL THROMBOSIS</b> DUE TO <b>15 YEARS</b> (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO <b>20 YEARS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANEMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 HOURS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 August, 19 59</b> , to <b>6 August, 19 59</b> , that I last saw the deceased alive on <b>6 August, 19 59</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26 N Summit AVE Gaithersburg, Maryland</b> DATE SIGNED <b>20 Aug 1959</b> ACTUAL SIGNATURE <b>Gorden S. Rosenberger</b> M.D. PHYSICIAN'S NAME (Type) <b>Gorden S. Rosenberger, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13.14 Film G247 8-27-59 et

9268

## CERTIFICATE OF DEATH

Reg. Dist. No.

09212

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> County <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 mos. 2 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor San</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 9101 Renick Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>1 Silver Spring</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>B</u> Last <u>Davis</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1939</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Allison</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Self</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>daughter-</u>		Address <u>Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Chelomuscular decahant</u> DUE TO (c) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 8, 1959</u> , to <u>Aug 20, 1959</u> , that I last saw the deceased alive on <u>Aug 19, 1959</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. T. Joyce</u>		M.D. <u>Bethesda, Md</u>	
PHYSICIAN'S NAME (Type) <u>W. T. Joyce</u>		ADDRESS (Street, city or town, state) <u>Bethesda, Maryland</u>	
DATE SIGNED <u>8/20/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>AUG 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	



CASE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09213

9269

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		d. STREET ADDRESS <u>103 E. INDIAN SP DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>LYNN</u> Last <u>DeMott</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 25 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Att.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Motors</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES DeMott</u>		14. MOTHER'S MAIDEN NAME <u>FLORA AVERY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>ARMY</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Wife - Same AS Above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interal Valvulitis &amp; Endocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1959</u> , to <u>Aug 26, 1959</u> , that I last saw the deceased alive on <u>Aug 26, 1959</u> , and that death occurred at <u>9:15 M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marion Bankhead</u>		DATE SIGNED <u>8/26/59</u>	
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/31/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Aug 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>	

1951

CERTIFICATE OF DEATH

2509

STATE OF CALIFORNIA

County of \_\_\_\_\_  
City of \_\_\_\_\_  
I, \_\_\_\_\_, Registrar of the County of \_\_\_\_\_, do hereby certify that \_\_\_\_\_  
born \_\_\_\_\_ at \_\_\_\_\_  
died \_\_\_\_\_ at \_\_\_\_\_  
Cause of death \_\_\_\_\_  
Signed and sealed this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest Arthur Desmarais</u>		4. DATE OF DEATH <u>8-4-1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-99</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sgt. Police - Dept of State</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mass.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Desmarais</u>		14. MOTHER'S MAIDEN NAME <u>Adele Ganeau</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Ordn. W.W. #1 none</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 HOURS</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>EMPHYSEMA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH</u> , 19 <u>57</u> , to <u>AUG. 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>AUG. 3</u> , 19 <u>59</u> , and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>		DATE SIGNED <u>AUG 4 1959</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		ADDRESS (Street, city or town, state) <u>WASH 12 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FROM

Attest on this 11th day of April, 1933

THE SECRETARY OF HEALTH

THE J. H. HARRIS CO. REGISTERED

9270

## CERTIFICATE OF DEATH

09215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 18 <b>4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>13,200 Lutes Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SHIRLEY</b> Middle <b>ANN</b> Last <b>DRAUGHAN</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/27/41</b>
9. AGE (In years last birthday) <b>18</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALVAH L. DRAUGHAN</b>		14. MOTHER'S MAIDEN NAME <b>LULA F. COX</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Alvah L. Draughan, 13,200 Lutes Lane Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>Spastic birth injury (cerebral palsy)</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>351x</b> (c) <b>2 days</b> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 27</b> , 19 <b>59</b> , to <b>Aug 29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 28</b> , 19 <b>59</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Patrick C. Jameson</b> M.D.		ADDRESS (Street, city or town, state) <b>12020 Georgia</b> DATE SIGNED <b>8/30/59</b>	
PHYSICIAN'S NAME (Type) <b>PATRICK C. JAMESON</b>		<b>Wheaton, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>	22b. DATE THEREOF <b>8/31/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>FRIES CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>FRIES, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE OF DEATH

2270

0917

Canal thermometer  
operative with wing (long)

15050  
8/30/57

22 Aug 57  
22 Aug 57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9207

CERTIFICATE OF DEATH

09216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		d. STREET ADDRESS <u>Chester, Maryland Box 47 17X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Shellcross</u> Last <u>Dreer</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 29, 1881</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa. Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Nicholas D. Dreer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret S. Vansant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Washington San. &amp; Hosp. Records</u>	
17. INFORMANT <u>Washington San. &amp; Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Neurofibromatosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26, 1959</u> , to <u>Aug. 4, 1959</u> , that I last saw the deceased alive on <u>Aug. 4, 1959</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park Md.</u>	
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>		DATE SIGNED <u>8-4-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar S. Lane</u>		ADDRESS <u>Chapel Hill Md</u>	
24a. REC'D BY REGISTRAR <u>Aug 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

CERTIFICATE OF DEATH

200

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JAN 10 1900		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		MILITARY SERVICE		REMARKS	
JAN 10 1835		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		ARMY		NO	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF REGISTRAR	
JAN 10 1900		BALTIMORE, MD.		HEART DISEASE		NATURAL		JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		MILITARY SERVICE		REMARKS	
JAN 10 1835		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		ARMY		NO	

9271

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>10 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. STREET ADDRESS <u>6504 Stoneham Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>Wilhelm</u> Last <u>Dyker</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>19</u> Year <u>1969</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 6-1878</u>
9. AGE (In years, last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jan Augustin Dyker</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Driesen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>345-04-5553</u>	
17. INFORMANT <u>Hospital Records &amp; Son</u>		Address <u>6504 Stoneham Rd. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line, (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arterio sclerosis</u> DUE TO (c) <u>undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-2-</u> , 19 <u>59</u> , to <u>8-19-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-10-</u> , 19 <u>59</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>LW Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>8-19-59</u>	
PHYSICIAN'S NAME (Type) <u>LW Malin M.D.</u>		<u>Riverdale, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kras</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OF ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

9272

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>76 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Essie</u> Middle <u>M</u> Last <u>Ely</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 26-1882</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		9b. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>	
11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Charles W. Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Connell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John B. Ely, Gaithersburg Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic cardio-renal disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>8/22/</u> <u>1959</u> , that I last saw the deceased alive on <u>8/20/</u> <u>1959</u> , and that death occurred at <u>2</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 Russell Ave., Gaithersburg, Maryland.</u> DATE SIGNED <u>8/22/59</u>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		DATE SIGNED <u>8/22/59</u>	
PHYSICIAN'S NAME (Type) <u>Frank J. Broschart</u>		ADDRESS <u>8 Russell Ave., Gaithersburg, Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form No. 1, 1955

DATE OF DEATH

PLACE

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

SEX

AGE

DATE OF BIRTH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9273									
CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. LENGTH OF STAY IN 1b <b>1 days</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1620 "V" Street</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERITANO</b>					4. DATE OF DEATH Month Day Year <b>August 1 1959</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-31-59</b>		9. AGE (In years last birthday) yrs. <b>26</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Peter J. ERITANO</b>					14. MOTHER'S MAIDEN NAME <b>Grace Elizabeth BRUCE</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(Father) Peter J. ERITANO</b>		Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 mgs</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>31 July</b> , 19 <b>59</b> , to <b>1 August</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1 August</b> , 19 <b>59</b> , and that death occurred at <b>3:22PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>8-3-59</b> ACTUAL SIGNATURE <b>D. Harris</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b> PHYSICIAN'S NAME (Type) <b>D. HARRIS, LT, MC, USN</b> <b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest P. Roberts</b> <b>1748 Wisconsin Ave. N.W. Washington, D.C.</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>		

2051182XV2

9233

CERTIFICATE OF DEATH

1. Name of deceased

2. Age

3. Sex

4. Race

5. Date of death

6. Place of death

7. Cause of death

8. Manner of death

9. Date of burial

10. Place of burial

11. Name of funeral home

12. Signature of physician

13. Name of informant

14. Signature of informant

15. Name of registrar

16. Signature of registrar

17. Date of registration

18. Time of registration

19. Signature of registrar

20. Seal of registrar

21. Name of hospital

22. Name of hospital

23. Name of hospital

24. Name of hospital

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09220

9274

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>64 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Riva</b> Middle <b>(none)</b> Last <b>Essrick</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 6, 1921</b>		9. AGE (In years last birthday) <b>38</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hyman Krakuzin</b>				14. MOTHER'S MAIDEN NAME <b>Rose Sokol</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephritis</b> DUE TO <b>705.4</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Systemic Lupus Erythematosus</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 mons.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>June 2</b> , 19 <b>59</b> , to <b>August 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 5</b> , 19 <b>59</b> , and that death occurred at <b>7:50 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-5-59</b> ACTUAL SIGNATURE <b>George T. Bryan</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>George T. Bryan, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 6, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Sons - 3501 14th St., N.W.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

CERTIFICATE OF DEATH

9212

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1910		New York, N.Y.	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Jan 15, 1955		10:30 AM		Home		Dr. Smith		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Printed Name of Physician		Printed Name of Registrar		Printed Name of Informant		Printed Name of Witness		Printed Name of Coroner	
John Doe, M.D.		Jane Doe, Registrar		John Doe, Informant		Jane Doe, Witness		John Doe, Coroner	
Address of Deceased		Address of Registrar		Address of Informant		Address of Witness		Address of Coroner	
123 Main St, Baltimore, MD		456 Main St, Baltimore, MD		789 Main St, Baltimore, MD		101 Main St, Baltimore, MD		202 Main St, Baltimore, MD	

9275

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>181 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				d. STREET ADDRESS <b>4000 Cathedral Ave., NW - Apt. 221B</b>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Coyle</b> Last <b>EWEN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-26-97</b>	
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>		IF UNDER 24 HRS. Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>George S. EWEN</b>				14. MOTHER'S MAIDEN NAME <b>Jessica COOTS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WWI, WWII, Korea Unknown</b>			
INFORMANT <b>Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma, rectum, with metastases</b> <b>154x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (Cauntly) _____ (State) _____	
21. I certify that I attended the deceased from <b>February 13, 19 59</b> , to <b>August 13, 19 59</b> , that I last saw the deceased alive on <b>August 13, 19 59</b> , and that death occurred at <b>3:55P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-13-59</b>							
ACTUAL SIGNATURE <b>G. I. Walker</b> M.D. <b>U. S. Naval Hospital</b>				DATE SIGNED <b>8-13-59</b>			
PHYSICIAN'S NAME (Type) <b>G. I. WALKER, CAPT, MC, USN</b>				Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Crementation</b>		22b. DATE THEREOF <b>8-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hills Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawler's &amp; Sons, 1756 Penn. Ave. NW, Wash. DC</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# CERTIFICATE OF DEATH

2575

Ministry of Columbia

Washington

18 days

18 days

1000 Chestnut Ave. N.W. - 1000

1000 Chestnut Ave. N.W. - 1000

1000

1000

1000

1000

1000

1000

U. S. Navy

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9208

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09222

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park.</b>				c. LENGTH OF STAY IN 1b <b>56 Silver Spring,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>				d. STREET ADDRESS <b>11711 Berwick Rd.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Fairfax</b>				4. DATE OF DEATH Month Day Year <b>August 1, 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1959</b>		9. AGE (In years last birthday) yrs. <b>6</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Carl Spogard Fairfax</b>				14. MOTHER'S MAIDEN NAME <b>Tvonne Dorothy Goodeve</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>father</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis.</b> <b>762.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity</b> DUE TO (c) <b>Premature Separation Placenta</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/1, 1959</b> , to <b>8/1, 1959</b> , that I last saw the deceased alive on <b>8/1, 1959</b> , and that death occurred at <b>8:52 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>925 Pershing Dr., Silver Spring, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Raymond F. Chinn</b>				M.D. <b>925 Pershing Dr., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Raymond F. Chinn, M. D.</b>				<b>925 Pershing Dr., Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>8-1-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital, Takoma Park, Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>				ADDRESS <b>Washington Sanitarium and Hospital, Takoma Park, 12, Maryland</b>		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

2075211XV2

AUG 5 '59

Arthur S. Frank



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09223

9276

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN lb <u>10 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7706 Meadow Lane</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>7706 Meadow Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alma Lawrence Felker</u> First Middle Last <b>4. DATE OF DEATH</b> <u>Aug 30 1959</u> Month Day Year				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8-1-1895</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>64</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>ma</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Mo</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Albert W. Lawrence</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie Lee Witzel</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Edward P. Felker - 2</u> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u> <u> years</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>Frank J. Brosehart</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Brosehart</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>8-30-59</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>		<b>22b. DATE THEREOF</b> <u>8/31/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cem</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>3201 Bladenburg Rd MD</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cherry Chase Funeral Home</u> ADDRESS <u>5105 W. Main St Wash DC</u>				<b>24a. REC'D BY REGISTRAR</b> <u>SEP 2 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9235

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1890</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. EDUCATION <i>High School</i>	
9. RELIGION <i>Catholic</i>		10. RACE <i>White</i>	
11. PLACE OF DEATH <i>Home</i>		12. CAUSE OF DEATH <i>Heart Disease</i>	
13. MANNER OF DEATH <i>Natural</i>		14. SIGNATURE OF EXAMINER <i>J. H. Smith</i>	
15. SIGNATURE OF ATTENDING PHYSICIAN <i>Dr. J. H. Smith</i>		16. SIGNATURE OF CORONER <i>John J. Smith</i>	
17. SIGNATURE OF JURY <i>John J. Smith</i>		18. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
19. SIGNATURE OF DECEASED <i>John J. Smith</i>		20. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
21. SIGNATURE OF CLERK <i>John J. Smith</i>		22. SIGNATURE OF NOTARY <i>John J. Smith</i>	
23. SIGNATURE OF JURY <i>John J. Smith</i>		24. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
25. SIGNATURE OF DECEASED <i>John J. Smith</i>		26. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
27. SIGNATURE OF CLERK <i>John J. Smith</i>		28. SIGNATURE OF NOTARY <i>John J. Smith</i>	
29. SIGNATURE OF JURY <i>John J. Smith</i>		30. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
31. SIGNATURE OF DECEASED <i>John J. Smith</i>		32. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
33. SIGNATURE OF CLERK <i>John J. Smith</i>		34. SIGNATURE OF NOTARY <i>John J. Smith</i>	
35. SIGNATURE OF JURY <i>John J. Smith</i>		36. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
37. SIGNATURE OF DECEASED <i>John J. Smith</i>		38. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
39. SIGNATURE OF CLERK <i>John J. Smith</i>		40. SIGNATURE OF NOTARY <i>John J. Smith</i>	
41. SIGNATURE OF JURY <i>John J. Smith</i>		42. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
43. SIGNATURE OF DECEASED <i>John J. Smith</i>		44. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
45. SIGNATURE OF CLERK <i>John J. Smith</i>		46. SIGNATURE OF NOTARY <i>John J. Smith</i>	
47. SIGNATURE OF JURY <i>John J. Smith</i>		48. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
49. SIGNATURE OF DECEASED <i>John J. Smith</i>		50. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
51. SIGNATURE OF CLERK <i>John J. Smith</i>		52. SIGNATURE OF NOTARY <i>John J. Smith</i>	
53. SIGNATURE OF JURY <i>John J. Smith</i>		54. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
55. SIGNATURE OF DECEASED <i>John J. Smith</i>		56. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
57. SIGNATURE OF CLERK <i>John J. Smith</i>		58. SIGNATURE OF NOTARY <i>John J. Smith</i>	
59. SIGNATURE OF JURY <i>John J. Smith</i>		60. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
61. SIGNATURE OF DECEASED <i>John J. Smith</i>		62. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
63. SIGNATURE OF CLERK <i>John J. Smith</i>		64. SIGNATURE OF NOTARY <i>John J. Smith</i>	
65. SIGNATURE OF JURY <i>John J. Smith</i>		66. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
67. SIGNATURE OF DECEASED <i>John J. Smith</i>		68. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
69. SIGNATURE OF CLERK <i>John J. Smith</i>		70. SIGNATURE OF NOTARY <i>John J. Smith</i>	
71. SIGNATURE OF JURY <i>John J. Smith</i>		72. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
73. SIGNATURE OF DECEASED <i>John J. Smith</i>		74. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
75. SIGNATURE OF CLERK <i>John J. Smith</i>		76. SIGNATURE OF NOTARY <i>John J. Smith</i>	
77. SIGNATURE OF JURY <i>John J. Smith</i>		78. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
79. SIGNATURE OF DECEASED <i>John J. Smith</i>		80. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
81. SIGNATURE OF CLERK <i>John J. Smith</i>		82. SIGNATURE OF NOTARY <i>John J. Smith</i>	
83. SIGNATURE OF JURY <i>John J. Smith</i>		84. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
85. SIGNATURE OF DECEASED <i>John J. Smith</i>		86. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
87. SIGNATURE OF CLERK <i>John J. Smith</i>		88. SIGNATURE OF NOTARY <i>John J. Smith</i>	
89. SIGNATURE OF JURY <i>John J. Smith</i>		90. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
91. SIGNATURE OF DECEASED <i>John J. Smith</i>		92. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
93. SIGNATURE OF CLERK <i>John J. Smith</i>		94. SIGNATURE OF NOTARY <i>John J. Smith</i>	
95. SIGNATURE OF JURY <i>John J. Smith</i>		96. SIGNATURE OF WITNESSES <i>John J. Smith</i>	
97. SIGNATURE OF DECEASED <i>John J. Smith</i>		98. SIGNATURE OF NEAREST RELATIVE <i>John J. Smith</i>	
99. SIGNATURE OF CLERK <i>John J. Smith</i>		100. SIGNATURE OF NOTARY <i>John J. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9209

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

09224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hvatt, Maryland</u>		1615.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. and Hosp.</u>		d. STREET ADDRESS <u>1400 Langley Way.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FLAVEN, MR. JOHN PATRICK</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-10</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMERSON RESEARCH</u>	
11. BIRTHPLACE (State or foreign country) <u>KV</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN FLAVEN</u>		14. MOTHER'S MAIDEN NAME <u>Catherine McCarthy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>   If yes, give war or dates of service <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>262 12 7897</u>	
INFORMANT <u>W Fink RN</u>		Address <u>WASH SAN and Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Insufficiency</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epidermoid carcinoma, undifferentiated, lung</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/23</u> , 19 <u>59</u> , to <u>8/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>59</u> , and that death occurred at <u>1035 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Marvin L. Kolkin</u>		ADDRESS (Street, city or town, state) <u>M.D. 8485 Fenton Street, S.S., Md.</u>	
PHYSICIAN'S NAME (Type) <u>MARVIN L. KOLKIN</u>		DATE SIGNED <u>8/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT 1, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>254 CARROLL ST. N.W. D.C.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>AUG 31 '59</u>			



CERTIFICATE OF DEATH

Blackford

also called boy

known as

A

2015 2817

W.M. II

Marvin L. Korkin



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9277

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>2 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8201 Kentbury Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NANCY</b> Middle <b>JOHNSON</b> Last <b>FLEMING</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>6</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 25, 1901</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cleveland, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Anders Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Larson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Husband</b> Address <b>Same as Item #2</b>		17. CHAPMAN C. FLEMING	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Ca. of Lung, Liver, Spleen, Spleen &amp; Skull</b> (c) <b>Carcinoma of Left Breast. Removed. Aug. 1956</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b> <b>12 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1958</b> , to <b>6 Aug. 1959</b> , that I last saw the deceased alive on <b>3 Aug. 1959</b> , and that death occurred at <b>2:00</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7936 Old Georgetown Rd. 8/6/59</b> DATE SIGNED <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>John G. Ball</b>		M.D. <b>7936 Old Georgetown Rd. 8/6/59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN G. BALL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/8/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda 14, Md.</b>	
24a. REC'D BY REGISTRAR <b>Aug 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneiss</b>	

Robert A. Humphrey, Bethesda, Md.

Wanted 8/8/52 Mr. Lincoln Secretary Prince George Co., Md.

JOHN C. BELL

1950 Old Georgetown Rd. 6/8/52  
Bethesda 14, Maryland

Montgomery  
Bethesda  
2 Years  
8201 Kentucky Drive  
Mandy Johnson  
Blaine  
White  
Aug. 25, 1951  
Bethesda, Md.  
None  
John C. Bell  
Bethesda 14, Maryland  
Sent on Aug. 12  
Bethesda, Md.  
11 11  
1951  
1952

9278

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanatorium</u>		d. STREET ADDRESS <u>215 EMERSON NW</u> <u>3000 McComas Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>LAST First Middle</u> <u>Flicker, Harry</u>		4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-69</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>26</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Gov. Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cincinnati Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Flicker</u>		14. MOTHER'S MAIDEN NAME <u>wife Emma Louise Flicker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Mrs Edna Simpson</u>		Address <u>215 EMERSON NW</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Aug 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 20</u> , 19 <u>59</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Walter K. Angerine</u>	ADDRESS (Street, city or town, state) <u>6350-13th St, NW, Wash. D.C.</u> DATE SIGNED <u>8/26/59</u>
PHYSICIAN'S NAME (Type) <u>—</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-29-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Luncane Hane</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hane</u>

Page 4

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

Wash. D.C.

Warrant of Arrest

Resident of the District of Columbia

Charles H. Hays

11-6-69

Wife: White

Retired from work

Charles H. Hays

Resident of the District of Columbia

Wife: White

Retired from work



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9279

## CERTIFICATE OF DEATH

Reg. Dist. No.

09227

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Montgomery</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4611 Hunt Avenue</b>			d. STREET ADDRESS <b>4611 Hunt Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA WERNER FONKEN</b>			4. DATE OF DEATH Month Day Year <b>August 2, 1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 18, 1878</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days Hours Min. <b>0 14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Sterling, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Franklin Werner</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Pegg</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>579-42-6933B</b>			17. INFORMANT <b>George H. Fonken - Item #2-husband</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Failure</b> DUE TO (c) <b>Coronary Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>1 hr.</b> <b>2 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Arteriosclerosis</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>June 54</b> to <b>8/2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Jan 20, 1959</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>5707 W. Conner Ave</b>			DATE SIGNED <b>8/3/59</b>		
ACTUAL SIGNATURE <b>Frank Y. Jagers, Jr.</b>			M.D. <b>5707 W. Conner Ave</b>		
PHYSICIAN'S NAME (Type) <b>Frank Y. Jagers, Jr.</b>			<b>Chevy Chase 15, Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans. Bur.</b>		22b. DATE THEREOF <b>8/5/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cem.</b>	
22d. LOCATION (City, town, or county)		(State) <b>Whiteside County, Illinois</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>			24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9280		Item 9 FilmG247 8-25-59 et				09228			
CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>P.O. Box 283</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie D</u> Middle <u>Frazier</u> Last <u>Frazier</u>			4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1959</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-20-21</u>		9. AGE (In years last birthday) <u>38 yr.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic helper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Isaac Frazier</u>					14. MOTHER'S MAIDEN NAME <u>Bessie Miles</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>0</u>		INFORMANT <u>Mary C. Owens</u> Address <u>Same - Sister</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>237x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Encephalomalacia</u> DUE TO (c) <u>Tumor, Parietal lobe, left cerebrum</u>								INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status post-operative</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>8/4</u> , 19 <u>59</u> , to <u>8/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/17</u> , 19 <u>59</u> , and that death occurred at <u>9:20 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 Wisconsin Avenue, Bethesda, Md.</u> DATE SIGNED									
ACTUAL SIGNATURE <u>Robert G. Brewer</u>					M.D. <u>8218 Wisconsin Avenue, Bethesda, Md.</u>				
PHYSICIAN'S NAME (Type) <u>Robert G. Brewer</u>									
22a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>8/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove.</u>		22d. LOCATION (City, town, or county) (State) <u>Emory Grove, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suwoda</u> ADDRESS <u>Rockville, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>AUG 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

Montgomery  
Guthrie  
2. Suburban Hospital P.O. Box 183  
Fragier  
11-22-21  
Montgomery  
Rosaire Miller  
Mont C. Lewis Gene - 2. 11

Montgomery  
Guthrie  
2. Suburban Hospital P.O. Box 183  
Fragier  
11-22-21  
Montgomery  
Rosaire Miller  
Mont C. Lewis Gene - 2. 11

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

9281

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 FilmG247 8-21-59 et

Reg. Dist. No.

09229

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Marland</b> b. COUNTY <b>Montg.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN lb <b>1 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington Grove</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jerrys Raw Bar</b>			d. STREET ADDRESS <b>110 Ridge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Addison</b> Last <b>Frazier</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>21,</b> Year <b>1959</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/16/1913</b> 1923	9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Va.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Lester Frazier</b>			14. MOTHER'S MAIDEN NAME <b>Blanch Pullen</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WN2</b>		17. INFORMANT <b>Hazel L. Frazier</b> Address <b>Item 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; laceration</b> <b>976x</b> DUE TO <b>Bullet wound in rt. skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>976x</b> DUE TO <b>Bullet wound in rt. skull</b> (c) <b>976x</b> DUE TO <b>Bullet wound in rt. skull</b>					INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>976x</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self inflicted bullet wound in rt. skull</b>			
20c. TIME OF INJURY Hour <b>5:00</b> p. m. Month, Day, Year <b>8/2/59</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>restaurent</b>	
20f. (City or town) <b>Gaithersburg</b>		20g. (County) <b>Montg.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/21/59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ParkLawn</b>	
22d. LOCATION (City, town, or county) <b>Rockville. Md.</b>		22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg. Md.</b>			24a. REC'D BY REGISTRAR <b>AUG 25 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

• • •

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				09230	
9282				Items 11, 13, 14 Film G248 9-11-59 et	
CERTIFICATE OF DEATH				Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> c. LENGTH OF STAY IN 1b <b>2 weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS REST HOME</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>5521 COLORADO AVENUE, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>E</b> Last <b>Frech</b> 4. DATE OF DEATH <b>XX 8 31 1959</b> 5. SEX <b>m</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>8/18/68</b> 9. AGE (In years last birthday) <b>91</b> yrs. 10. IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min. 11. BIRTHPLACE (State or foreign country) <b>New York State</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanical Draftsman - U. S. Gov't. War Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>S. Gov't. War Dept.</b>		11. BIRTHPLACE (State or foreign country) <b>New York State</b>	
13. FATHER'S NAME <b>FRECH, Theobald</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>579-20-2719</b>		INFORMANT <b>Mrs. Marie F. Hopkins, 814 Rowen Rd., Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive failure</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b> <b>5 days</b> <b>10 yrs approx</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pyelonephritis due to obstructive uropathy</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>July</b> , 1959, to <b>August 31, 1959</b> that I last saw the deceased alive on <b>August 31, 1959</b> and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8641- Colesville Road Aug 31, 59</b> DATE SIGNED <b>ARTHUR E. KIRK</b>	
ACTUAL SIGNATURE <b>Ralph E. Patten</b> M.D.		PHYSICIAN'S NAME (Type) <b>RALPH E. PATTEN M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b> 22b. DATE THEREOF <b>9/3/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL MAUSOLEUM</b> 22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY INC. Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 3 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kirk</b>	

5880



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/55

9283

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09231

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Summer near Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Summer near Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5104 Westpath Way</b>		d. STREET ADDRESS <b>5104 Westpath Way</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>M.</b> Middle <b>M'liss</b> Last <b>Freeman</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/1/1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joshua A. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Marian S. Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Robt. L. Freeman</b>		Address <b>5104 Westpath Way (Summer)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Approx 3 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>9</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>28 Aug 19 59</b> to <b>28 Aug 19 59</b> , that I last saw the deceased alive on <b>28 Aug 19 59</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1746 K St., N. W., Washington, D. C.</b> DATE SIGNED <b>29 Aug 59</b>			
ACTUAL SIGNATURE <b>Clyde P. Reeves</b>		M.D. <b>1746-K-St. NW</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. Buchsbaum</b>		ADDRESS <b>3034 M St., N.W., D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9284					CERTIFICATE OF DEATH				
Reg. Dist. No. 215									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN Ib <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>501 Seward Square, S. E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Cleo</b> Last <b>FREEMAN</b>					4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-14-93</b>		9. AGE (In years last birthday) yrs. <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Armed Forces</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps</b>		11. BIRTHPLACE (State or foreign country) <b>Arkansas</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Robert E. FREEMAN</b>					14. MOTHER'S MAIDEN NAME <b>Alice DURAM</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>WWI &amp; WWII</b>		INFORMANT			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chorea, progressive chronic</b> <b>355x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>August 13</b> , 19 <b>59</b> , to <b>August 21</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 21</b> , 19 <b>59</b> , and that death occurred at <b>9:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda 12, Maryland</b> DATE SIGNED <b>8-22-59</b> ACTUAL SIGNATURE <b>R. L. Christy</b> M.D. <b>U. S. Naval Hospital</b> PHYSICIAN'S NAME (Type) <b>R. L. CHRISTY, CAPT, MC, USN</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-26-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Mattingly</b> <b>R. A. Mattingly Funeral Home, 131 11th St. SE, WDC</b>					24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

9884

9884

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

NAME OF DECEASED

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

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DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

9285

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09233

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural Laytonsville</b> 50 years HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Gaithersburg Rt. #1</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Montgomery</b> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural Laytonsville</b> STREET ADDRESS (If rural give location) <b>Gaithersburg Rt. #1 Lived on Farm</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>William H. Fulks</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 5 19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Jan. 8 1878</b>	9. AGE last birthday <b>81</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William R. Fulks</b>				14. MOTHER'S MAIDEN NAME <b>Mary V. Ward</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT & ADDRESS <b>John P. Fulks Bethesda, Md</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <b>Arteriosclerosis Heart</b> ANTECEDENT CAUSE(S) DUE TO <b>Disease as manifest</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>by Congestive Heart Failure</b> (C)						INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1952 Aug 5</b> , to <b>Aug 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 4</b> , 19 <b>59</b> , and that death occurred at <b>6:32</b> A.M. from the causes and on the date stated above. SIGNATURE <b>Jack Schumacher</b> M.D. ADDRESS (Street, city, town, state) <b>Gaithersburg, Md.</b> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 8 -59</b>		NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>	
24. REC'D BY REGISTRAR DATE <b>AUG 10 1959</b>		REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b> ADDRESS <b>Laytonsville, Md.</b>			

# CERTIFICATE OF DEATH

9282

Name of Deceased William H. Fries		Date of Death Jan. 6, 1952	
Sex Male		Race White	
Age 61		Marital Status Single	
Place of Birth Maryland		Usual Residence Baltimore, Md.	
Cause of Death Unknown		Date of Death Jan. 6, 1952	
Signature of Physician [Signature]		Signature of Registrar [Signature]	
Date of Death Jan. 6, 1952		Place of Death Baltimore, Md.	
Name of Deceased William H. Fries		Date of Death Jan. 6, 1952	
Sex Male		Race White	
Age 61		Marital Status Single	
Place of Birth Maryland		Usual Residence Baltimore, Md.	
Cause of Death Unknown		Date of Death Jan. 6, 1952	
Signature of Physician [Signature]		Signature of Registrar [Signature]	
Date of Death Jan. 6, 1952		Place of Death Baltimore, Md.	

RECEIVED

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md., and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
Item 18 Film 248 9-25-59 ams																			
9286																			
CERTIFICATE OF DEATH																			
Reg. Dist. No. 215																			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>✓</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. LENGTH OF STAY IN 1b <b>3 days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Triangle</b> <b>83X-3</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>					d. STREET ADDRESS <b>304 Courtney Drive Thompson Pk.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>Regina</b> Middle <b>Ellen</b> Last <b>GALICZYNSKI</b>					4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>19 59</b>														
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-18-59</b>		9. AGE (In years lost birthday) yrs. <b>2</b> Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					11. BIRTHPLACE (State or foreign country) <b>Virginia</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				
13. FATHER'S NAME <b>Carl J. GALICZYNSKI</b>					14. MOTHER'S MAIDEN NAME <b>Lillian T. KRUPA</b>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>Yes</b>					16. SOCIAL SECURITY NO. <b>None</b>					INFORMANT Address <b>(Father) Carl J. GALICZYNSKI Same as #2</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>Multiple Congenital Anomalies</b>										INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.1</b> DUE TO <b>(Harelip, single, left; Cleft palate, anterior, left; Spina bifida, occult, limbosacral; Calcaneo-valgus deformity; Patent ductus arteriosus, large; interventricular septal defect; and many other deformities)</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>septal defect; and many other deformities)</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>29 July</b> , 19 <b>59</b> , to <b>1 August</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1 August</b> , 19 <b>59</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.										DATE SIGNED									
ACTUAL SIGNATURE <b>D. Harris</b>					ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b>					DATE SIGNED <b>8-3-59</b>									
PHYSICIAN'S NAME (Type) <b>D. HARRIS, LT, MC, USN</b>					U.S. Naval Hospital, NNMC, Bethesda Md.														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>8-5-59</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>					22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest A. Adams</b>					ADDRESS <b>ADAMS Funeral Home 4748 Wisconsin Ave. N.W. Washington D.C. '59</b>					24a. REC'D BY REGISTRAR <b>AUG 6 '59</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>				

90000000X00

AUG 6 '59

Arthur L. Kraus

Age

Sex

Color

Married

Place of Birth

Place of Death

Occupation

Cause of Death

Immediate Cause

Intermediate Cause

Underlying Cause

Contributing Cause

Duration of Illness

Time of Death

Place of Death

Time of Death

Signature of Physician

Signature of Registrar

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

Signature of Informant

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Signature of Informant

Signature of Informant

Signature of Informant

9210

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington San. &amp; Hospital</u>				d. STREET ADDRESS <u>11007 Amherst Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>FREMA</u> Middle <u>(NMN)</u> Last <u>GARBER</u>				4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/95</u>	9. AGE (In years lost birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswnf.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>DORIS</u>				14. MOTHER'S MAIDEN NAME <u>MINERVA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>577-03-1406</u> INFORMANT <u>PT's Hosp. Record</u> Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastases</u> <u>151 X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>59</u> , to <u>8/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/26</u> , 19 <u>59</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>				ADDRESS (Street, city or town, state) <u>7733 Alaska Ave N.W. Washington D.C. - 8/26/59</u>			
PHYSICIAN'S NAME (Type) <u>BENJAMIN ISAACSON</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/28/1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>DC Lodge Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u> ADDRESS <u>4717-9th Ave</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECLARATION OF DEATH

Declarant

Deceased

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

Place of death

9287

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hosp.</b>				d. STREET ADDRESS <b>3717 Underwood St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>St. Clair</b> Last <b>Gardiner</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>15</b> Year <b>1959</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/1895</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Decorah Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles H. Gardiner</b>				14. MOTHER'S MAIDEN NAME <b>Louise Saintclair</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>World #1</b>		17. INFORMANT <b>W. S. Gardiner Jr. Item 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous heart disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>Wash. D.C. 3821 14th. St. N. W.</b>				24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





9288

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Shawnee</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>1 wk</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10225 Green Forest Dr</u>			d. STREET ADDRESS <u>POPLAR</u> <u>735 Poplar St</u>		
3. NAME OF DECEASED (Type or print) <u>Arthur Walter Geyer</u>			4. DATE OF DEATH <u>Aug 11 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kan.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Jacob Geyer</u>			14. MOTHER'S MAIDEN NAME <u>Helene Zable</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>510-16-8860</u>		17. INFORMANT <u>Ethel Geyer (wife)</u> Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>			22b. DATE THEREOF <u>8/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>
					22d. LOCATION (City, town, or county) (State) <u>Topeka, Kansas</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>			24a. REC'D BY REGISTRAR <u>Aug 14 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>	
3. AGE <u>45</u>		4. RACE <u>WHITE</u>	
5. DATE OF DEATH <u>1950-10-15</u>		6. TIME OF DEATH <u>10:30 AM</u>	
7. PLACE OF DEATH <u>HOME</u>		8. STREET <u>123 MAIN ST.</u>	
9. CITY <u>ALBANY</u>		10. COUNTY <u>SARATOGA</u>	
11. STATE <u>NEW YORK</u>		12. ZIP CODE <u>12202</u>	
13. MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		14. OCCUPATION <u>CLERK</u>	
15. CAUSE OF DEATH <u>HEART DISEASE</u>		16. MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE	
17. SIGNATURE OF MEDICAL EXAMINER <u>[Signature]</u>		18. SIGNATURE OF DECEASED <u>[Signature]</u>	
19. SIGNATURE OF WITNESS <u>[Signature]</u>		20. SIGNATURE OF DECEASED <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9289 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Watson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cecil</b> Middle <b>James</b> Last <b>Gibson</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 13, 1932</b>
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Claude Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Slone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Korean</b>		16. SOCIAL SECURITY NO. <b>235-54-2022</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Massive Hemorrhage, Intotracheo-Broncheal Tree</b> 204.3 DUE TO (b). <b>Acute Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <b>less than 30 Minutes</b> <b>Approx. 1 yr.</b>	
21. I certify that I attended the deceased from <b>March 30</b> , 19 <b>59</b> , to <b>August 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 5</b> , 19 <b>59</b> , and that death occurred at <b>11:10 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8/6/59</b>			
ACTUAL SIGNATURE <b>Arthur R. Rothman</b> M.D. PHYSICIAN'S NAME (Type) <b>ARTHUR R. ROTHMAN, M.D.</b>		The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		22b. DATE THEREOF <b>8/7/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Fairmont, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumpfrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9290									
CERTIFICATE OF DEATH									
Reg. Dist. No. 09239									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rockville</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>					d. STREET ADDRESS <u>2651-16<sup>th</sup> St. N.W.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Lida</u> Middle <u>A</u> Last <u>Gilbert</u>					4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1959</u>				
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/1859</u>		9. AGE (In years last birthday) yrs. <u>100</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hous ewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Henry</u>					14. MOTHER'S MAIDEN NAME <u>Rachel Clements</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>no</u> INFORMANT <u>LOUIS P. HILWINE</u> Address <u>Rockville, Md. 11411 Rockwell Pkwy.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, broncho-</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>left inguinal hernia</u> INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u> <u>40 yrs.</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>31 July</u> , 19 <u>59</u> , to <u>1 AUG</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1 AUG</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7659 Georgetown Rd.</u> DATE SIGNED <u>8-1-59</u> ACTUAL SIGNATURE <u>John M. Wyman</u> M.D. PHYSICIAN'S NAME (Type) <u>John M. Wyman M.D. Bethesda 14, Maryland</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>8/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St., N.W. Wash. D.C.</u>					24a. REC'D BY REGISTRAR <u>AUG 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

50. 7-8-12



9291

## CERTIFICATE OF DEATH

09240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd Md</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Buck Lodge Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Glover</b> Last <b>Glover</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Greenkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Country Club</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Glover</b>		14. MOTHER'S MAIDEN NAME <b>Martha Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Margaret L Heard</b>		Address <b>Landover Hills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic glomerulonephritis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 months</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> p. m. <b>—</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that I attended the deceased from <b>Sept 19 58</b> to <b>16 Aug 1959</b> , that I last saw the deceased alive on <b>14 Aug 1959</b> , and that death occurred at <b>3:30 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boyd, Md</b> DATE SIGNED <b>16 Aug 59</b>			
ACTUAL SIGNATURE <b>John E. Fawcett</b> M.D.		DATE SIGNED <b>16 Aug 59</b>	
PHYSICIAN'S NAME (Type) <b>JOHN E. FAWCETT MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/18/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fawcett</b>	

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VS A15 (4)  
15M 9/58

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10500

CERTIFICATE OF DEED

1832

THAT

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Witness my hand and seal this 1st day of January 1832.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9292  
CERTIFICATE OF DEATH

09241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hrs</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase 15</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>18403 Dounybrook Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eugene</u> <u>Harold</u> <u>Gough</u>		4. DATE OF DEATH Month Day Year <u>8</u> <u>19</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Gough</u>		14. MOTHER'S MAIDEN NAME <u>Ida M. Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Gimes H. Gough - Son - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330x Subarachnoid Hemorrhage</u> DUE TO (b) <u>Captured aneurysm, left anterior communicating artery</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/19/59</u> to <u>8/19/59</u> , that I last saw the deceased alive on <u>8/19/59</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Tuohy</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JOHN H. TUOHY</u>		<u>7720 Wisconsin Ave., Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8/22/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Boonville, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S.H. Hines Co.</u> ADDRESS <u>2901-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	

12/11/21  
John H. Dwyer

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9293  
CERTIFICATE OF DEATH

09242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>151 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mississippi</b> b. COUNTY <b>Tylertown</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>61X-3</b> d. STREET ADDRESS <b>Route 5</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Nercellia</b> Middle <b>Evelyn</b> Last <b>Grubbs</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 59</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1892</b>	9. AGE (In years last birthday) yrs. <b>67</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>James Payne</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ball</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>427-48-9796</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive Heart Failure</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Subendocardial infarction</b> DUE TO <b>Refractory anemia (compensated)</b> (c) <b>Hemoglobinosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b> <b>2 weeks</b> <b>5 years</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <b>March 5</b> , 19 <b>59</b> , to <b>August 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 3</b> , 19 <b>59</b> , and that death occurred at <b>11:40P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>8-4-59</b>						
ACTUAL SIGNATURE <b>Arthur I. Grayzel</b>		M.D. <b>Arthur I. Grayzel, M. D.</b>				
PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>		22b. DATE THEREOF <b>8/4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Tylertown Cemetery</b>		
22d. LOCATION (City, town, or county)		(State) <b>Tylertown, Mississippi</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 5 '59</b>		
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>						

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of board of health		18. Signature of city or county	
19. Signature of state		20. Signature of federal government		21. Signature of international organization	
22. Signature of local organization		23. Signature of religious organization		24. Signature of educational institution	
25. Signature of business organization		26. Signature of labor union		27. Signature of fraternal organization	
28. Signature of other organization		29. Signature of other person		30. Signature of other person	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9211

## CERTIFICATE OF DEATH

09243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>	
c. LENGTH OF STAY IN 1b <b>4½ years</b>		d. STREET ADDRESS <b>7401 GARLAND AVENUE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7401 GARLAND AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>LEE</b> Last <b>GUNDERSON</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/19/92</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Burroughs Company</b>	
11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN A. GUNDERSON</b>		14. MOTHER'S MAIDEN NAME <b>SARAH TOLSFSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>184-01-1583A</b>	
17. INFORMANT <b>Mrs. Georgia S. Gunderson, 7401 Garland Ave. Takoma Park, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Metastases to Liver, Pancreas &amp; Abdominal wall</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 2<sup>nd</sup>, 1942</b> to <b>Aug 29, 1959</b> , that I last saw the deceased alive on <b>Aug 29, 1959</b> and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W B Wardrop MD</b>		ADDRESS (Street, city or town, state) <b>837 Bonaparte St Silver Spring, Md</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM B. WARDROP</b>		DATE SIGNED <b>9/29/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Mem. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Geo. County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR <b>SEP 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>			

MEDICAL CERTIFICATION

CRIMINAL RECORDS

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CHARGE

CLERICAL

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9212

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Penna.</i> b. COUNTY <i>Pottsville</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edith</i> First <i>None</i> Middle <i>Hale</i> Last		4. DATE OF DEATH Month <i>8</i> Day <i>26</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-12-87</i>
9. AGE (In years lost birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.	11. IF UNDER 24 HRS. Months <i>7</i> Days <i>1</i> Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>EDUCATION</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Elisha Smith</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>-----</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Washington Sanitarium &amp; Hospital Records</i>		Address <i>-----</i>	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>151X</i> DUE TO <i>Carcinoma Stomach</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>-----</i> DUE TO <i>-----</i> (c) <i>-----</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> <i>3 years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-----</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August 27</i> , 19 <i>59</i> to <i>August 26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Aug 26</i> , 19 <i>59</i> , and that death occurred at <i>8:20 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lyle Williams</i> M.D.		ADDRESS (Street, city or town, state) <i>8700 Blossville Rd - Schuylkill</i>	
PHYSICIAN'S NAME (Type) <i>Lyle Williams</i>		DATE SIGNED <i>Aug 26 1959</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/26/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Odd Fellows Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Pottsville, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph L. Williams</i> ADDRESS <i>1756 Penna. Ave. NW, D.C.</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kline</i> DATE <i>AUG 31 '59</i>	
24b. REGISTRAR'S SIGNATURE			

1. *XR*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

— 22 —

9294

CERTIFICATE OF DEATH

09245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>			
c. LENGTH OF STAY IN lb <u>1 hr 29 min</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1d. STREET ADDRESS <u>1912 HENRY ROAD</u>			
3. NAME OF DECEASED (Type or print) <u>MARK First Middle Last</u> <u>INFANT (MALE) Hamernik</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/23/59</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>29</u>		11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>29</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>Daniel J Hamernik</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Sokol</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
INFORMANT Address <u>Daniel J. Hamernik-father-item 2d</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity + Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Premature delivery - 22 wks</u> DUE TO (c) <u>15 hrs</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/23</u> , 19 <u>59</u> , to <u>8/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/23</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph J. O'Neil</u>				ADDRESS (Street, city or town, state) <u>Rockville, Md</u>			
PHYSICIAN'S NAME (Type) <u>Joseph O'Neil</u>				DATE SIGNED <u>Aug 26 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Carmel, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>AUG 26 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

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CENTRAL AIR CO. DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

9295

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New York</b> b. COUNTY <b>✓</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Elmhurst, Long Island</b> <b>69X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>2718 McIntosh Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Esmond</b> Middle <b>Lemond</b> Last <b>Haywood</b>			4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1936</b>	9. AGE (In years last birthday) <b>23</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Marine</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>	
13. FATHER'S NAME <b>Ben Haywood</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
14. MOTHER'S MAIDEN NAME <b>Dorothy Taylor</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <b>191-30-8021</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure in Postoperative Period, following correction of Tetralogy of Fallot.</b> <b>754.0</b> DUE TO <b>Congenital Cyanotic Heart Disease,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Tetralogy of Fallot.</b> DUE TO (c) <b>23 Years</b> INTERVAL BETWEEN ONSET AND DEATH <b>23 Years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 7, 19 59</b> to <b>August 28, 19 59</b> , that I last saw the deceased alive on <b>August 28, 19 59</b> , and that death occurred at <b>7:30 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>N. Perryman Collins</b>			ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/29/59</b>		
PHYSICIAN'S NAME (Type) <b>N. Perryman Collins, M.D.</b>			National Institutes of Health <b>Bethesda 14, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>9-1-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <b>Florida</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Frazier Funeral Home</b> ADDRESS <b>389-R.T. Ave. N.W.</b>			
24a. REC'D BY REGISTRAR DATE <b>SEP 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinas</b>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9296 CERTIFICATE OF DEATH

09247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>26 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,213 GEORGIA AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MINNA</b> Middle <b>E.</b> Last <b>HEITMULLER</b>				4. DATE OF DEATH Month <b>AUG.</b> Day <b>13</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/30/70</b>	
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER - OWN HOME - retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>			
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN SPENGLER</b>				14. MOTHER'S MAIDEN NAME <b>OTELIA KRAFT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Mr. T. L. Heitmuller, 3001 Beech St., N.W.</b>				Address <b>Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>15 years</b> <b>30 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 10, 1958</b> to <b>Aug 13, 1959</b> that I last saw the deceased alive on <b>Aug 13, 1959</b> , and that death occurred at <b>2:39 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave Silver Spring, Md.</b> DATE SIGNED <b>8/13/59</b>							
ACTUAL SIGNATURE <b>John J. Curry</b>				PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>8/15/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knead</b>							

MEDICAL CERTIFICATION

00317

CERTIFICATE OF DEATH

2298

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09248

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN life <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8662 Piney Branch Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>8662 Piney Br. Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>T. Robert Henriques</u>		<b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>21</u> Year <u>1959</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10-14-1958</u>		<b>9. AGE</b> (In years last birthday) yrs. <u>10</u> Months <u>7</u> Days <u>7</u> Hours <u></u> Min. <u></u> IF UNDER 1 YEAR IF UNDER 24 HRS.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>DC</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Vic E. Henriques</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucinda McCrea</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Lucinda Henriques</u> Address <u>Stem 2</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vomiting</u> DUE TO (c) <u>upper Respiratory Infection</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 days</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> M.D.						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b> <u>8-21-59</u>						
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>8/24/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PARKLAWN CEMETERY</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>MONTGOMERY COUNTY, MARYLAND</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Liska</u>						<b>ADDRESS</b> <u>SILVER SPRING, MD.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>DATE AUG 24 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1924

0297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF JAILER		23. SIGNATURE OF PRISONER		24. SIGNATURE OF WARDEN	
25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF DETECTIVE		27. SIGNATURE OF PATROLMAN	
28. SIGNATURE OF STREET CARRIER		29. SIGNATURE OF MESSENGER		30. SIGNATURE OF MESSENGER	
31. SIGNATURE OF MESSENGER		32. SIGNATURE OF MESSENGER		33. SIGNATURE OF MESSENGER	
34. SIGNATURE OF MESSENGER		35. SIGNATURE OF MESSENGER		36. SIGNATURE OF MESSENGER	
37. SIGNATURE OF MESSENGER		38. SIGNATURE OF MESSENGER		39. SIGNATURE OF MESSENGER	
40. SIGNATURE OF MESSENGER		41. SIGNATURE OF MESSENGER		42. SIGNATURE OF MESSENGER	
43. SIGNATURE OF MESSENGER		44. SIGNATURE OF MESSENGER		45. SIGNATURE OF MESSENGER	
46. SIGNATURE OF MESSENGER		47. SIGNATURE OF MESSENGER		48. SIGNATURE OF MESSENGER	
49. SIGNATURE OF MESSENGER		50. SIGNATURE OF MESSENGER		51. SIGNATURE OF MESSENGER	
52. SIGNATURE OF MESSENGER		53. SIGNATURE OF MESSENGER		54. SIGNATURE OF MESSENGER	
55. SIGNATURE OF MESSENGER		56. SIGNATURE OF MESSENGER		57. SIGNATURE OF MESSENGER	
58. SIGNATURE OF MESSENGER		59. SIGNATURE OF MESSENGER		60. SIGNATURE OF MESSENGER	
61. SIGNATURE OF MESSENGER		62. SIGNATURE OF MESSENGER		63. SIGNATURE OF MESSENGER	
64. SIGNATURE OF MESSENGER		65. SIGNATURE OF MESSENGER		66. SIGNATURE OF MESSENGER	
67. SIGNATURE OF MESSENGER		68. SIGNATURE OF MESSENGER		69. SIGNATURE OF MESSENGER	
70. SIGNATURE OF MESSENGER		71. SIGNATURE OF MESSENGER		72. SIGNATURE OF MESSENGER	
73. SIGNATURE OF MESSENGER		74. SIGNATURE OF MESSENGER		75. SIGNATURE OF MESSENGER	
76. SIGNATURE OF MESSENGER		77. SIGNATURE OF MESSENGER		78. SIGNATURE OF MESSENGER	
79. SIGNATURE OF MESSENGER		80. SIGNATURE OF MESSENGER		81. SIGNATURE OF MESSENGER	
82. SIGNATURE OF MESSENGER		83. SIGNATURE OF MESSENGER		84. SIGNATURE OF MESSENGER	
85. SIGNATURE OF MESSENGER		86. SIGNATURE OF MESSENGER		87. SIGNATURE OF MESSENGER	
88. SIGNATURE OF MESSENGER		89. SIGNATURE OF MESSENGER		90. SIGNATURE OF MESSENGER	
91. SIGNATURE OF MESSENGER		92. SIGNATURE OF MESSENGER		93. SIGNATURE OF MESSENGER	
94. SIGNATURE OF MESSENGER		95. SIGNATURE OF MESSENGER		96. SIGNATURE OF MESSENGER	
97. SIGNATURE OF MESSENGER		98. SIGNATURE OF MESSENGER		99. SIGNATURE OF MESSENGER	
100. SIGNATURE OF MESSENGER		101. SIGNATURE OF MESSENGER		102. SIGNATURE OF MESSENGER	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09249

9298

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Triangle</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>83x-3</b> d. STREET ADDRESS <b>#1 Oakdale Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Darline</b> Last <b>HILL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>19 59</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-2-59</b>		9. AGE (In years last birthday) yrs. <b>15</b>		IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min. <b>15</b>		IF UNDER 24 HRS. Hours <b>15</b> Min. <b>15</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Buster HILL</b>						14. MOTHER'S MAIDEN NAME <b>Margaret CHAMBERS</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(F) Buster Hill, same as #2</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital Heart Disease</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 12</b> , 19 <b>59</b> , to <b>August 17</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 17</b> , 19 <b>59</b> , and that death occurred at <b>5:30P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-18-59</b>															
ACTUAL SIGNATURE <b>H. L. Walton</b>				M.D. <b>U. S. Naval Hospital</b>				DATE SIGNED <b>8-18-59</b>							
PHYSICIAN'S NAME (Type) <b>H. L. WALTON, LT, MC, USN</b>				Bethesda 14, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>				22b. DATE THEREOF <b>8-18-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		22d. LOCATION (City, town, or county) <b>LaFollette</b>		(State) <b>Tenn.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>						ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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2

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

32883

1. Name of deceased: *John Doe*  
2. Sex: *Male*  
3. Age: *45*  
4. Date of birth: *10-15-1900*  
5. Place of birth: *Virginia*  
6. Usual residence: *123 Main St, Richmond, Va*  
7. Cause of death: *Heart Disease*  
8. Date of death: *August 27, 1945*  
9. Time of death: *2:30 PM*  
10. Place of death: *U.S. Naval Hospital*  
11. Signature of physician: *H. E. Watson, M.D.*  
12. Signature of registrar: *J. E. Smith*  
13. Date of registration: *August 28, 1945*  
14. Registrar's office: *Richmond, Va*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9213 CERTIFICATE OF DEATH

Reg. Dist. No.

09250

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Oakton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barton Tokoma Park</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>		d. STREET ADDRESS <u>200 Hibbard Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>Wes</u> Last <u>Hodgins</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/20/43</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. - American</u>	
13. FATHER'S NAME <u>George W. Hodgins</u>		14. MOTHER'S MAIDEN NAME <u>Lois E. Loney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Chart (Fathic) 200 Hibbard St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>466x</u> DUE TO <u>Cerebral arrest -</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Biphasal vascular collapse</u> DUE TO <u>Thrombosis of portal vein (Banti's syndrome)</u> (c) <u>13 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minute</u> <u>30 minute</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 11, 1959</u> to <u>Aug 27, 1959</u> that I last saw the deceased alive on <u>Aug 27, 1959</u> , and that death occurred at <u>1:59 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lyle Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>8700 Colasville Rd.</u> DATE SIGNED <u>8/27/59</u>	
PHYSICIAN'S NAME (Type) <u>Lyle Williams</u>		<u>Scherbaum, Paul</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Flinn Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Oakton Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Monroe King</u> ADDRESS <u>DM Pickens &amp; Sons, Inc.</u>		24a. REC'D BY REGISTRAR <u>Aug 31 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Robert S. Frank</u>

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1912

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9214

CERTIFICATE OF DEATH

Reg. Dist. No.

09251

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>7 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>517 ALBANY AVE.</b>				e. STREET ADDRESS <b>517 ALBANY AVE.</b>			
3. NAME OF DECEASED (Type or print) <b>HARRY E. HORAN</b>				4. DATE OF DEATH <b>8-27-59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-11-70</b>	
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY HORAN</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET BAYLES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Magdalene Plant 1530 N.E. 42nd St. FLA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension and atherosclerosis.</b> (c) <b>Stroke</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Chn</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug 24/59</b> to <b>Aug 27, 1959</b> that I last saw the deceased alive on <b>Aug 27/59</b> , 19____, and that death occurred at <b>1944 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Francis J. Holman, M.D.</b>				ADDRESS (Street, city or town, state) <b>507 Underwood ST. N.W. Wash. D.C.</b>			
PHYSICIAN'S NAME (Type) <b>Francis J. Holman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Holman</b>				ADDRESS <b>3821-14 Th. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 31 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chilton S. Hanna</b>			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED <b>JOHN J. BROWN</b></p>		<p>AGE <b>45</b></p>		<p>SEX <b>Male</b></p>		<p>RACE <b>White</b></p>	
<p>DATE OF DEATH <b>1914-11-10</b></p>		<p>TIME OF DEATH <b>10:30 AM</b></p>		<p>PLACE OF DEATH <b>Home</b></p>		<p>CAUSE OF DEATH <b>Heart Disease</b></p>	
<p>DATE OF BIRTH <b>1869-07-10</b></p>		<p>PLACE OF BIRTH <b>Massachusetts</b></p>		<p>EDUCATION <b>High School</b></p>		<p>OCCUPATION <b>Teacher</b></p>	
<p>DATE OF MARRIAGE <b>1900-05-15</b></p>		<p>NAME OF SPOUSE <b>Elizabeth Brown</b></p>		<p>DATE OF INTERMENT <b>1914-11-12</b></p>		<p>PLACE OF INTERMENT <b>Catholic Cemetery</b></p>	
<p>DATE OF DEATH <b>1914-11-10</b></p>		<p>TIME OF DEATH <b>10:30 AM</b></p>		<p>PLACE OF DEATH <b>Home</b></p>		<p>CAUSE OF DEATH <b>Heart Disease</b></p>	
<p>DATE OF BIRTH <b>1869-07-10</b></p>		<p>PLACE OF BIRTH <b>Massachusetts</b></p>		<p>EDUCATION <b>High School</b></p>		<p>OCCUPATION <b>Teacher</b></p>	
<p>DATE OF MARRIAGE <b>1900-05-15</b></p>		<p>NAME OF SPOUSE <b>Elizabeth Brown</b></p>		<p>DATE OF INTERMENT <b>1914-11-12</b></p>		<p>PLACE OF INTERMENT <b>Catholic Cemetery</b></p>	

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 1914





STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1917

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Page 4  
death. Pages 1 and 2 should be filed with the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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051

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09253  
9299  
CERTIFICATE OF DEATH  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>37hr. 20min.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> <b>83X-3</b> d. STREET ADDRESS <b>1003 S. Frederick St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby Boy JACKSON</b>		4. DATE OF DEATH Month Day Year <b>August 24 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-22-59</b>
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William E. JACKSON</b>		14. MOTHER'S MAIDEN NAME <b>Marlene Kay RUSCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia, neonatorum</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 22</b> , 19 <b>59</b> , to <b>August 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 23</b> , 19 <b>59</b> , and that death occurred at <b>12:05A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 8-24-59</b> ACTUAL SIGNATURE <b>Fred W Grello</b> M.D. PHYSICIAN'S NAME (Type) <b>Fred W. GRELO, LT, MC, USN Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 8-24-59</b>		22b. DATE THEREOF <b>8-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brookmere Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. W. Humphrey Funeral Home, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>			

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Page 4  
death. Pages 1 and 2 should be filled with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09254	
9300										CERTIFICATE OF DEATH	
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Spencerville, (Rural)</b>					c. LENGTH OF STAY IN life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Spencerville, (Rural))</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS <b>/</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Galeb First James Johnson</b>					4. DATE OF DEATH Month <b>Aug</b> Day <b>7</b> Year <b>1999</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 25, 1880</b>		9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					13. FATHER'S NAME <b>William Johnson</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					INFORMANT <b>Herbert Johnson</b> Address <b>Spencerville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C R D</b> DUE TO <b>Arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>mh</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>June 19, 1949</b> , to <b>Aug. 7, 1959</b> that I last saw the deceased alive on <b>Aug. 7, 1959</b> and that death occurred at <b>8:07 AM</b> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <b>Webster Sewell</b> M.D.					DATE SIGNED <b>8.9.59</b> <b>Arthur S. Kline</b>						
PHYSICIAN'S NAME (Type) <b>Webster Sewell</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>8/10/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Round Oak,</b>		22d. LOCATION (City, town, or county) (State) <b>Spencerville, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>					ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		

10801

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

2300



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09255

9301

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Montgomery</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Montgomery</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Colesville</b>		LENGTH OF STAY (in this place) <b>1 year</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural Gaithersburg</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Marilea Nursing Home</b>				STREET ADDRESS (If rural give location) <b>/</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Emily</b> (Middle) <b>R.</b> (Last) <b>Johnson</b>				(Month) <b>Aug.</b> (Day) <b>16</b> (Year) <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Sept 27 1887</b>	9. AGE last birthday <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lawson Day</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT & ADDRESS <b>Marilea Nursing Home</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <b>Cerebral Infarction</b>						<b>48 hrs</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cerebral Thrombosis</b>						<b>6 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Cerebral Arteriosclerosis</b>						<b>Indefinite</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Hypertension + Congestive Failure</b>						<b>5 yrs</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>7/1/58</b> , to <b>8/16/59</b> , that I last saw the deceased alive on <b>8/15/59</b> , and that death occurred at <b>1:25 P.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Stephen D. Jones</b> M.D.				ADDRESS (Street, city, town, state) <b>Rockville Md</b>		DATE SIGNED <b>8/18/59</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Aug. 19 59</b>		NAME OF CEMETERY OR CREMATORY <b>Mountain Chapel</b>		LOCATION (City, town, or county) (State) <b>Comas Md</b>	
24. REC'D BY REGISTRAR DATE <b>AUG 19 '59</b>		REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Royce Barber</b> ADDRESS <b>Laytonsville, Md.</b>			

2080

9302

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09256

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Henry Johnson</u>				4. DATE OF DEATH Month Day Year <u>8 24 19 59</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18 1932</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundryman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Johnson</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH BARNES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Joseph Johnson, 112 North St. Rockville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> <u>982X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration of pulmonary artery</u> DUE TO (c) <u>Stab Wound.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 1/2 in laceration left arm</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Stab wound in upper left chest</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>9:20 p.m. 8-24 1959</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>	
20f. (City or town) <u>Rockville Md.</u>				20g. (County) <u>Montgomery</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Our Lady's Chapel</u>	
22d. LOCATION (City, town, or county) <u>Madley's Neck, Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>				ADDRESS <u>Leonardtwn, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 27 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cuthbert</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 9305

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF CORONER _____		SIGNATURE OF JURY _____	
CITY _____		COUNTY _____		STATE _____	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9303

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>Washington, D.C.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sharon Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>47X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>3426 16th St. N.W. Apt. 107</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Thomas Jones</b>		4. DATE OF DEATH Month Day Year <b>August 14, 1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/22/70</b>
9. AGE (In years last birthday) <b>88</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Treasury Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Jones</b>		14. MOTHER'S MAIDEN NAME <b>Emma Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-24-4488A</b>	
17. INFORMANT <b>Pearl A. Jones</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 days</b> <b>10+ years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 8</b> , 19 <b>59</b> , to <b>Aug 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 11</b> , 19 <b>59</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Kenesa Ave Apt 8/14/59</b> DATE SIGNED <b>Neil P. Campbell</b> ACTUAL SIGNATURE <b>Neil P. Campbell</b> M.D. PHYSICIAN'S NAME (Type) <b>Neil P. Campbell</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8/16/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Mem. Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pleasantville, N.J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>Aug 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Washington 9, D.C.</b>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9304

CERTIFICATE OF DEATH

119258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>8216 Nolte Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Lee</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-59</u>
9. AGE (In years last birthday) <u>19</u>		10. IF UNDER 1 YEAR Months <u>19</u> Days <u>14</u> Hours <u>30</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Billy Jules Jones</u>		14. MOTHER'S MAIDEN NAME <u>Hopkins, Vetta Virginia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>8216 Nolte Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5 aelectasia</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. (b) <u>20 hrs</u> (c) <u>20 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/20</u> , 19 <u>59</u> , to <u>8/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/20/59</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard Auld</u>		ADDRESS (Street, city or town, state) <u>809 Yous Mill Rd, Rockville Md.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD AULD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>8/21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Floral Garden Park</u>		22d. LOCATION (City, town, or county) (State) <u>High Point, N. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>		24a. REC'D BY REGISTRAR <u>Aug 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

2074231XV2

CENTRAL STATE OF DEATH

2304

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09259

Reg. Dist. No.

9305

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>4711 Warren St.</u>	
3. NAME OF DECEASED (Type or print) <u>Adeline</u> First <u>Kimbell</u> Middle <u></u> Last		4. DATE OF DEATH <u>Aug. 30</u> 19 <u>59</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 7 1877</u>
9. AGE (In year last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Guttenberg, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Schaffer</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Flick BECKETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Peritonitis</u> <u>572.1</u> DUE TO (b) <u>Reptures, Ruptured Aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>48 hours</u> <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/30/59</u> to <u>8/30/59</u> , that I last saw the deceased alive on <u>8/29/59</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>J.M. Bird</u> M.D. <u>Sandy Spring, Md.</u>		<u>SANDY SPRING, MARYLAND</u>	
22a. BURIAL CREATION, REMOVAL (Specify) <u>SEPT 1, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>FAIRVIEW, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler Sons, Wash. D. C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 3 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kins</u>			

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

10000

Name of Deceased		Date of Death	
J. M. Bird		1912	
Age		Sex	
35		Male	
Place of Birth		Cause of Death	
New York		Heart Disease	
Occupation		Duration of Illness	
Farmer		10 days	
Signature of Physician		Signature of Registrar	
J. M. Bird		J. M. Bird	
Date of Signature		Date of Signature	
1912		1912	

9216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 hrs. 20 min.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Jan E Hosp.</u>		d. STREET ADDRESS <u>7503 Flower Ave</u>	
3. NAME OF DECEASED (Type or print) <u>James Noeman Kimble</u>		4. DATE OF DEATH <u>8-13</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-86</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Radiologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>X-Ray</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James D. Kimble</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Lane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Pl.'s Hosp. Record</u>	
17. INFORMANT Address <u>Pl.'s Hosp. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>2040</u> DUE TO <u>Arteriosclerotic Leukemic low platelets</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>The cause of Leukemia</u> DUE TO (c) <u>The cause of Leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>16 month</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/13/59</u> , 19 <u>59</u> , to <u>8/13/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/13/59</u> , 19 <u>59</u> , and that death occurred at <u>500 Underwood St NW</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Chas. H. Volleton</u> M.D. ADDRESS (Street, city or town, state) <u>500 Underwood St NW</u> DATE SIGNED <u>8/13/59</u> PHYSICIAN'S NAME (Type) <u>Chas. H. Volleton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 17, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Madison Mills Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Madison Mills, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Canal St NW DC</u>		24. REC'D BY REGISTRAR DATE <u>AUG 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

9306

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09261

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>56</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>805 BRANTFORD AVENUE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ALTHEA WOODLAND NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>B.</b> Last <b>KING</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>16</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/1/67</b>
9. AGE (In years lost birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PART OWNER (retired) Equitable Purchasing Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM B. BRITTAIN</b>		14. MOTHER'S MAIDEN NAME <b>unknown PAYNE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mrs. Gertrude E. King, 2800 Quebec St., N.W.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO <b>446X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Uremia</b> DUE TO <b>Nephrosclerosis</b> (c) <b>Antenartherosclerosis generalized.</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 weeks</b> <b>10 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August, 19 53</b> to <b>Aug 16, 19 59</b> that I last saw the deceased alive on <b>Aug 16, 19 59</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ralph F. Patten</b>		ADDRESS (Street, city or town, state) <b>8641- Colesville Road Aug 16, 59</b>	
PHYSICIAN'S NAME (Type) <b>RALPH F. PATTEN M.D.</b>		DATE SIGNED <b>Silver Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond J. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>AUG 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

2300

10201

1

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. Some words like "John" and "Mary" are faintly visible.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9307

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. LENGTH OF STAY IN 1b <b>D.O.A</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SUBURBAN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John HUNTER KRISKO</b>		4. DATE OF DEATH <b>Aug. 17 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/06</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Rice Bakery</b>	
10. FATHER'S NAME <b>John Krisko</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Army</b>		15. SOCIAL SECURITY NO. <b>577-1839-73</b>	
16. INFORMANT <b>John Krisko, Jr. - Son</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Blaschaw</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Blaschaw</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>8-17-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>Aug 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kneiss</b>	

STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9308

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21 Film G247 8-31-59 et

## CERTIFICATE OF DEATH

09263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>41 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>Spartanburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Inman</b> d. STREET ADDRESS <b>R. R. #2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elta Lois Lancaster</b>		4. DATE OF DEATH Month Day Year <b>August 25, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1899</b>
9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Francis M.-Howard</b>		14. MOTHER'S MAIDEN NAME <b>Lou Sudduth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>197-03-0224</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock secondary to generalized toxemia</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pelvic abscess</b> DUE TO <b>postoperative status - pelvic</b> (c) <b>exacerbation for Carcinoma Cervix</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3-4 wks</b> <b>4 wks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15, 1959</b> to <b>August 25, 1959</b> , that I last saw the deceased alive on <b>August 25, 1959</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-26-59</b> ACTUAL SIGNATURE <b>Edward D. McLaughlin</b> M.D. PHYSICIAN'S NAME (Type) <b>Edward D. McLaughlin, M. D.</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>8/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Landrum Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Spartanburg, S. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24. REC'D BY REGISTRAR <b>AUG 28 '59</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	



# CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE 18

9308

NAME OF DECEASED Edward D. McLaughlin, Jr.		SEX Male	
DATE OF BIRTH May 12, 1899		PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION None		CAUSE OF DEATH Heart failure	
TIME OF DEATH 11:00 A.M.		PLACE OF DEATH Home	
DATE OF DEATH May 12, 1950		TIME OF DEATH 11:00 A.M.	
NAME OF DECEASED Edward D. McLaughlin, Jr.		SEX Male	
DATE OF BIRTH May 12, 1899		PLACE OF BIRTH Baltimore, Maryland	
OCCUPATION None		CAUSE OF DEATH Heart failure	
TIME OF DEATH 11:00 A.M.		PLACE OF DEATH Home	
DATE OF DEATH May 12, 1950		TIME OF DEATH 11:00 A.M.	



I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the Baltimore Health Department.  
 Robert A. Thompson, Registrar  
 Baltimore, Maryland  
 May 12, 1950



9309

CERTIFICATE OF DEATH

Reg. Dist. No.

09264

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
c. LENGTH OF STAY IN TB <b>22 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8918 COLESVILLE ROAD</b>		d. STREET ADDRESS <b>1 8918 COLESVILLE ROAD</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edith Estelle Landers</b>		4. DATE OF DEATH <b>Aug 9 1959</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/11/77</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK - Post Office, U.S. Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SILAS WRIGHT DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>ACHSAH L. GROOMES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Eugene Landers, 8918 Colesville Road</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4344 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Silver Spring, Md.</b> DUE TO (c) <b>18 mo.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 1958</b> to <b>Aug 9 1959</b> , that I last saw the deceased alive on <b>Aug 7 1959</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John N. Andrews</b>		ADDRESS (Street, city or town, state) <b>9601 Colesville Rd Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>		DATE SIGNED <b>8/9/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville Meth. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Laytonsville, Montgomery Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

8800

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35 years		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5 feet 10 inches		10. WEIGHT 170 pounds	
11. CAUSE OF DEATH Suicide by gunshot		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Memphis, Tennessee		14. DATE OF DEATH April 4, 1968		15. TIME OF DEATH 2:01 PM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF WITNESS John Edgar Hoover		18. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		19. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		20. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
21. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		22. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		23. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		24. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		25. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
26. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		27. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		28. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		29. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		30. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
31. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		32. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		33. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		34. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		35. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
36. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		37. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		38. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		39. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		40. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
41. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		42. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		43. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		44. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		45. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
46. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		47. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		48. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		49. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		50. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
51. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		52. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		53. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		54. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		55. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
56. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		57. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		58. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		59. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		60. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
61. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		62. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		63. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		64. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		65. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
66. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		67. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		68. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		69. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		70. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
71. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		72. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		73. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		74. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		75. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
76. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		77. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		78. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		79. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		80. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
81. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		82. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		83. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		84. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		85. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
86. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		87. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		88. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		89. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		90. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
91. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		92. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		93. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		94. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		95. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	
96. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		97. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		98. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		99. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray		100. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mrs. A. C. Ray	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9310 CERTIFICATE OF DEATH									
Reg. Dist. No. 09265									
1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>9 yrs 10 mo</u> x <u>Bethesda</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>					d. STREET ADDRESS <u>4407 Lywood La.</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Rutherford</u> Middle <u>Barrett</u> Last <u>Lank</u>					4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1959</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 13, 1919</u>		9. AGE (In years last birthday) <u>40</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woodworking</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William Jefferis Lank</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Stanton</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>NONE</u>				
17. INFORMANT <u>Samuel Th. Lank</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis</u> <u>12 yr -</u>									
INTERVAL BETWEEN ONSET AND DEATH <u>1 wk +</u> <u>6 mo +</u> <u>14 yr +</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>8-19</u> , 19 <u>59</u> , to <u>8-20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-19</u> , 19 <u>59</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Wyrth Post Baker</u> M.D.					DATE SIGNED <u>1635 HARVARD ST. 8-21-59</u>				
PHYSICIAN'S NAME (Type) <u>WYRTH POST BAKER</u>					<u>Washington DC</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 8-21-59</u>					22b. DATE THEREOF				
22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>					22d. LOCATION (City, town, or county) (State) <u>Naimans Corner, Delaware.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>				
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>				

MEDICAL CERTIFICATION

*[Faint, mostly illegible text from the reverse side of the document, appearing as bleed-through. Some words like "NAME", "SEX", "AGE", "DATE OF BIRTH", "PLACE OF BIRTH", "OCCUPATION", "CAUSE OF DEATH", "MANNER OF DEATH", "DATE OF DEATH", "PLACE OF DEATH", "SIGNATURE", "DATE", "TIME", "LOCATION", "WITNESSES", "DEATH CERTIFICATE", "REGISTERED", "FILED", "INDEXED", "SERIALIZED", "SEARCHED", "FILED", "INDEXED", "SERIALIZED", "SEARCHED" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 10/57

9311

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>5813 Melbourne Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Sandra</b> Middle <b>Kay</b> Last <b>Lawson</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1954</b>
9. AGE (In years last birthday) yrs. <b>5</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Child)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Adrian Lawson</b>		14. MOTHER'S MAIDEN NAME <b>Natalie Aylestock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest in postoperative period (surgical correction of Tetralogy of Fallot)</b> 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Tetralogy of Fallot</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 23, 19 59</b> , to <b>August 28, 19 59</b> , that I last saw the deceased alive on <b>August 28, 19 59</b> , and that death occurred at <b>9:40A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 8-28-59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>E. C. Brockenbrough, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Edwin C. Brockenbrough, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Fairfax Co. Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur &amp; Thomas</b> <b>Arlington Funeral Home</b>		24. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Thomas</b>			



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9312

## CERTIFICATE OF DEATH

Reg. Dist. No.

09267

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Alabama</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Robinwood Station</b>			
3. NAME OF DECEASED (Type or print) First <b>Tom</b> Middle <b>(none)</b> Last <b>Layton</b>				4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1890</b>	
9. AGE (In years lost birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gold Digger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John Layton</b>				14. MOTHER'S MAIDEN NAME <b>Mollie Gambell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tracheal obstruction</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Blastomycosis of skin</b> DUE TO (c) <b>Carcinoma of larynx</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>5 years</b> <b>10 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis; Osteoarthritis of spine</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 20</b> , 19 <b>59</b> , to <b>August 8</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 8</b> , 19 <b>59</b> , and that death occurred at <b>8:10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-9-59</b> ACTUAL SIGNATURE <b>Vincent T. Andriole</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Vincent T. Andriole, M. D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans Burial</b>				22b. DATE THEREOF <b>8/11/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Jefferson Memorial Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Birmingham Alabama</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

# CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1953

8317

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth	
John Doe		Male		45		White		1908		New York, N.Y.	
Date of Death		Place of Death		Cause of Death		Manner of Death		Occupation		Education	
July 15, 1953		Home		Heart Disease		Natural		Teacher		High School	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Zip	
[Signature]		Dr. J. Smith		123 Main St.		Baltimore		MD		21201	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Zip	
[Signature]		Dr. A. Jones		456 Oak St.		Baltimore		MD		21202	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's City		Coroner's State		Coroner's Zip	
[Signature]		Mr. B. Brown		789 Pine St.		Baltimore		MD		21203	
Registrar's Signature		Registrar's Name		Registrar's Address		Registrar's City		Registrar's State		Registrar's Zip	
[Signature]		Ms. C. Green		101 Elm St.		Baltimore		MD		21204	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09268

9313

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>66 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> <b>0358-2</b> d. STREET ADDRESS <b>2904 Cornwell Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Ann</b> Last <b>Leyko</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 59</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 11, 1953</b>		9. AGE (In years last birthday) <b>6</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Martin A. Leyko</b>				14. MOTHER'S MAIDEN NAME <b>Rita Muszynski Muszynska</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Upper GI bleeding</b> DUE TO <b>204.3</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphatic leukemia</b> (c) <b>Subdural hematoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>less than 24 hrs.</b> <b>24 months</b> <b>unknown</b>																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from <b>June 5</b> , 19 <b>59</b> , to <b>August 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 10</b> , 19 <b>59</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/10/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland																											
ACTUAL SIGNATURE <b>Jerry S. Trier</b>				M.D. <b>The Clinical Center</b>				PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M. D.</b>				22a. BURIAL, CREMATION, (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8-13-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b> ADDRESS <b>Dundalk, Md.</b>																		24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					

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control 6000 10000 15000 20000 25000 30000 35000 40000 45000 50000 55000 60000 65000 70000 75000 80000 85000 90000 95000 100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9314

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fakoma Park Spencerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ellsworth</u>		4. DATE OF DEATH <u>Aug. 13 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1861</u>
9. AGE (In years, last birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Light</u>		14. MOTHER'S MAIDEN NAME <u>Not Hannah Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-4-</u> <u>1959</u> , to <u>8-13-</u> <u>1959</u> , that I last saw the deceased alive on <u>8-6-</u> <u>1959</u> , and that death occurred at <u>5-25</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8/13/59</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		M.D. <u>[Signature]</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>254 Carroll St NW SE</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	







**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9315**  
**CERTIFICATE OF DEATH**

09270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>7 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>The District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X 3</b> d. STREET ADDRESS <b>101 Kennedy Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Hall</b> Last <b>Locraft</b>			4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>19 59</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 13, 1903</b>		9. AGE (In years last birthday) yrs. <b>55</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Architect</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>			
13. FATHER'S NAME <b>Bernard F. Locraft</b>			14. MOTHER'S MAIDEN NAME <b>Marie DeLacy</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Not available</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, organism unknown</b> <b>200.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Reticulum Cell Sarcoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>August 24, 1959</b> , to <b>August 31, 1959</b> , that I last saw the deceased alive on <b>August 31, 1959</b> , and that death occurred at <b>6:35 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Richard C. Mechanic</i>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>9-1-59</b>			
PHYSICIAN'S NAME (Type) <b>Richard C. Mechanic, M. D.</b>		National Institutes of Health <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Sept. 4/59</b>		22b. DATE THEREOF <b>Sept. 4/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wash. D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Costello</b>		ADDRESS <b>1722 North Capitol</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '59</b>			
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Parris</i>			

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09271

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>MONTGOMERY</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			c. LENGTH OF STAY IN 1b <b>3 Yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1511 FLORA LANE</b>				d. STREET ADDRESS <b>1511 FLORA LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARGARET</b> Middle <b>T.</b> Last <b>LORD</b>				<b>4. DATE OF DEATH</b> Month <b>AUG.</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/7/77</b>		9. AGE (In years lost birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM F. TYSER</b>				14. MOTHER'S MAIDEN NAME <b>HANNAH FERRY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>Miss Margaret T. Lord, 1511 Flora Lane</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Aug 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 21</u> , 19 <u>59</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter K. Angevine</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>6300 - 13th St., N.W., Wash. D.C. 8-24-59</b>			
PHYSICIAN'S NAME (Type) <b>WALTER K. ANGEVINE</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. BUMPHREY, INC.</b> <i>Raymond A. Zisk</i>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur E. Harris</i>				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911 BIRTH DATE

1911 BIRTH DATE

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9317 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**CERTIFICATE OF DEATH**

Reg. Dist. No.

09272

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Allegheny</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>50 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Dianne</b> Middle <b>Louise</b> Last <b>Loresch</b>				4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1949</b>		9. AGE (In years last birthday) <b>10</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry W. Loresch</b>				14. MOTHER'S MAIDEN NAME <b>Martha C. Peterson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Lymphoblastic Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>11 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 30</b> , 19 <b>59</b> , to <b>August 19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 19</b> , 19 <b>59</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jerry S. Trier</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8-20-59</b>			
PHYSICIAN'S NAME (Type) <b>Jerry S. Trier, M. D.</b>				The National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 8/24/59</b>		22b. DATE THEROF		22c. NAME OF CEMETERY OR CREMATORY <b>Allegheny Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsburg, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24c. REC'D BY REGISTRAR DATE <b>AUG 21 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

See D.H. No.

Name of deceased		Sex		Age		Date of birth		Place of birth		Usual residence		Cause of death		Date of death		Time of death		Place of death		Signature of physician		Signature of registrar	
John Doe		Male		45		Jan 1, 1900		Maryland		Baltimore		Heart disease		Jan 15, 1945		10:30 AM		Home		J. Smith		A. Jones	
Occupation		Married		Single		Widowed		Divorced		Never married		Previous illness		Duration of illness		Treatment		Last medical examination		Date of last medical examination		Date of death	
Teacher		Yes		No		No		No		No		None		3 weeks		Medicine		Jan 10, 1945		Jan 10, 1945		Jan 15, 1945	
Education		High school		College		University		Graduate		Postgraduate		Other		None		None		None		None		None	
Religion		Catholic		Protestant		Jewish		Muslim		Other		None		None		None		None		None		None	
Race		White		Negro		Other		None		None		None		None		None		None		None		None	
Date of death		Time of death		Place of death		Signature of physician		Signature of registrar		Date of death		Time of death		Place of death		Signature of physician		Signature of registrar		Date of death		Time of death	
Jan 15, 1945		10:30 AM		Home		J. Smith		A. Jones		Jan 15, 1945		10:30 AM		Home		J. Smith		A. Jones		Jan 15, 1945		10:30 AM	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9318

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>25 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>Loving</u> Last <u>Loving</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/31/09</u>	9. AGE (In years lost birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Diamond Cab. Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Julian H. Loving</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXX VIRGIA GRIMES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>320-124071</u> INFORMANT <u>Rose Loving Son</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary-hypertensive heart disease</u> (c) <u>Essential hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>  </u> to <u>8/30/59</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>8/30/59</u> , 19 <u>  </u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard J. Walsh</u> M.D.				ADDRESS (Street, city or town, state) <u>900-12th St. N.W.</u> DATE SIGNED <u>8/30/59</u>			
PHYSICIAN'S NAME (Type) <u>Bernard J. Walsh</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Nat'l. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>SEP 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneak</u>	

074

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1

AP

1933

CERTIFICATE OF DEATH

8312

CHIEF OF BUREAU  
OF VITAL RECORDS  
STATE OF NEW YORK  
FOR 1933

VITAL NUMBER

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9319

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Washington</u> <u>47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3613 Quesada St., N. W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>H.</u> Last <u>Lytzen</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/87</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>D. William Horgan</u>		14. MOTHER'S MAIDEN NAME <u>MARY SWEENEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>WALTER W. LYTZEN, 3613 QUESADA ST., N.W.</u>		Address <u>WASH., D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hepatic Necrosis</u> <u>585x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cholangitis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute pyelonephritis, Left</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1947</u> to <u>Aug 20, 1959</u> , that I last saw the deceased alive on <u>Aug 20, 1959</u> , and that death occurred at <u>230 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St Wash D.C.</u> DATE SIGNED <u>8/21/59</u>			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley Sons, Wash. D. C.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

9231

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09275

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5733 Crawford Dr</u>				d. STREET ADDRESS <u>5733 Crawford Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Olaf Maddren</u>				4. DATE OF DEATH Month Day Year <u>Aug 27 1959</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-1913</u>			
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Alfred G. Maddren</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-28142</u>					
17. INFORMANT <u>Mr. Eugene Jackson</u>				Address <u>Stn 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Found dead in bed</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u>				ADDRESS <u>1331 E. Montgomery Ave. Rockville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 31 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneas</u>	

MEDICAL CERTIFICATION







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1  
9320  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8720 Colesville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A</b> Last <b>MARLOWE, SR.</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/96</b>
9. AGE (In years lost birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Realtor (self-employed)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>ASHTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS R. MARLOWE</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-03-8193</b>	
17. INFORMANT <b>Mrs. Susanna M. Marlowe</b>		Address <b>8720 Colesville Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>15 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/19/1956</b> to <b>8/6/1959</b> , that I last saw the deceased alive on <b>7/17/1959</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Russell B. Arnold</b>		ADDRESS (Street, city or town, state) <b>8801 Colesville Road, Silver Spring, Md.</b>	
DATE SIGNED <b>8/6/59</b>		DATE SIGNED <b>Clairing P. Thomas</b>	
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D.</b>		PHYSICIAN'S NAME (Type) <b>Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>COLESVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>COLESVILLE, MONTGOMERY CO., MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>Raymond A. Fisk</b>		24b. REGISTRAR'S SIGNATURE <b>Clairing P. Thomas</b>	

3330

CERTIFICATE OF DEATH

DATE OF DEATH

SIGNATURE

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

SIGNATURE

DECEASED

SIGNATURE

*[Faint, illegible handwritten text, likely a narrative of the death]*

*[Faint, illegible handwritten text, likely a narrative of the death]*

DATE OF DEATH

SIGNATURE

DECEASED

SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9321

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

00277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HighPoint</u>				c. LENGTH OF STAY IN 1b <u>6 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5919 Mass.Avenue, NW-ext.</u>				e. STREET ADDRESS <u>5919 Mass.Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Bernardine</u> Middle <u>Fenwick</u> Last <u>Marsh</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1870</u>	
9. AGE (In years last birthday) <u>88 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Leonardtwn, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William A. Fenwick</u>				14. MOTHER'S MAIDEN NAME <u>Alice Herbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>--</u>		17. INFORMANT <u>Mrs. N. Ward Guthrie--#2d-Daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 7, 1959</u> , to <u>August 18, 1959</u> , that I last saw the deceased alive on <u>August 17, 1959</u> , and that death occurred at <u>1:30 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James W. Egan</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>7720 Wisconsin Ave., Bethesda, Md.</u> <u>8/18/59</u>			
PHYSICIAN'S NAME (Type) <u>James T. Ryan, Inc.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>				ADDRESS <u>317 Pa. Ave., SE</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 19 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. K. K.</u>			

18-00000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

9851

# CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-34		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. PLACE OF DEATH Baltimore, Md.		12. DATE OF DEATH 4-4-68		13. TIME OF DEATH 10:15 AM		14. CAUSE OF DEATH Suicide		15. MANNER OF DEATH Homicide	
16. MEDICAL HISTORY No known chronic disease.		17. PRESENT ILLNESS Depression		18. TREATMENT None		19. PHYSICIAN'S SIGNATURE [Signature]		20. COUNTY Baltimore	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF NEXT OF KIN [Signature]		23. SIGNATURE OF PHYSICIAN [Signature]		24. SIGNATURE OF CORONER [Signature]		25. SIGNATURE OF JURY [Signature]	

18-00000

18-00000

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9322**  
**CERTIFICATE OF DEATH**

09278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural* Woodfield</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural- Woodfield</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD Gaithersburg</b>				d. STREET ADDRESS <b>RFD Gaithersburg</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cora Idella Burdette Mathers</b>				4. DATE OF DEATH Month Day Year <b>August 2 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1878</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Woodfield, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Singleton King</b>				14. MOTHER'S MAIDEN NAME <b>Mary R.E. Burdette</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-32-2430</b>		17. INFORMANT Address <b>Mrs Lucy M. Braun, Gaithersburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>10 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 10, 1946</b> to <b>August 2, 1959</b> , that I last saw the deceased alive on <b>August 2, 1959</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Kerr</b>				ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		DATE SIGNED <b>8/4/59</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 5, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Woodfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Mylesworth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

9382

10277

COUNTY OF <u>ALLEGANY</u> STATE OF <u>MARYLAND</u>		DECEASED <u>JOHN J. BROWN</u>	
DATE OF DEATH <u>10-11-1918</u> TIME OF DEATH <u>10:00 AM</u>		PLACE OF DEATH <u>HOME</u>	
AGE <u>45</u> YEARS SEX <u>MALE</u>		OCCUPATION <u>LABORER</u>	
BIRTH <u>1873</u> PLACE OF BIRTH <u>ALLEGANY, PA.</u>		CAUSE OF DEATH <u>HEMIPLEGIC STROKE</u>	
PREVIOUS ILLNESS <u>NO</u>		MEDICAL ATTENDANCE <u>YES</u>	
BURIAL <u>YES</u> PLACE <u>ALLEGANY CEMETERY</u>		SIGNATURE OF DECEASED <u>None</u>	
SIGNATURE OF NEXT OF KIN <u>None</u>		SIGNATURE OF PHYSICIAN <u>None</u>	
SIGNATURE OF REGISTRAR <u>None</u>		SIGNATURE OF CLERK <u>None</u>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS ACT, AND IS NOT VALID FOR ANY OTHER PURPOSES.



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

9323

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9810 GA. AVE.</u>		d. STREET ADDRESS <u>1 9810 GA. AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>INEZ</u> Middle <u>MAY</u> Last <u>HEW</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1881</u>
9. AGE (In years less birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>William Allen</u>		14. MOTHER'S MAIDEN NAME <u>Ann Taliaferro</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Anne E. Buehl</u>		Address <u>2220 Rand Pl. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 14, 1954</u> , to <u>AUG. 13, 1959</u> , that I last saw the deceased alive on <u>AUG. 13, 1959</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ann E. Buehl</u>		ADDRESS (Street, city or town, state) <u>5206 Norwood Dr. Wash. D.C.</u>	
DATE SIGNED <u>8/13/59</u>			
PHYSICIAN'S NAME (Type) <u>Chas. Chas. Chas.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Lee</u>		ADDRESS <u>Wash. D. C.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara E. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9324

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

19280

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <del>MARYLAND</del> <b>D.C.</b> b. COUNTY <del>MONTGOMERY</del> <b>WASHINGTON</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>SILVER SPRING</del> <b>WASHINGTON</b> <b>47X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>7000 PINEY BRANCH ROAD, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>MAYO JR.</b> Last <b>MAYO JR.</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/77</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Mechanical Engineer</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>ROBERT MAYO, SR.</b>		14. MOTHER'S MAIDEN NAME <b>ANN EL IZA BASS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>WIFE (SAME AS ABOVE)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> <b>541.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Hemorrhage from Splenic Artery</b> (c) <b>Penetrating Duodenal Ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 days</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 18</b> , 19 <b>59</b> , to <b>Aug. 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 20</b> , 19 <b>59</b> , and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Philip H. Varner, M.D. 18620 Har. Ave., Silver Spring, Ind. 8/20/59</b>			
ACTUAL SIGNATURE <b>Philip H. Varner</b>		PHYSICIAN'S NAME (Type) <b>PHILIP H. VARNER</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/24/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 25 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

452

7.56

9325

## CERTIFICATE OF DEATH

09281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>34 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>South Charleston</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>85 x-3</b> d. STREET ADDRESS <b>213 Ninth Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Dolph McCloud</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1898</b>
9. AGE (In years last birthday) <b>60</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Radiator Shop Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John McCloud</b>		14. MOTHER'S MAIDEN NAME <b>Martha Drummond</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>236-07-9787</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pleural effusions</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic carcinoma of pleurae, lungs, &amp; lymph nodes</b> DUE TO (c) <b>Carcinoma of body of pancreas</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Miliary granulomatous disease of liver and spleen</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 10, 1959</b> to <b>August 13, 1959</b> , that I last saw the deceased alive on <b>August 13, 1959</b> , and that death occurred at <b>6:00P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles E. Mengel</b>		DATE SIGNED <b>8/14/59</b>	
PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>	22b. DATE THEREOF <b>8-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <b>South Charleston, W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey - Bethesda 14, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 17 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

3834

1932

Age 10

Wm. W. W. W.

North Washington

111 North Wayne

Age 10

101 North

101 North

101 North

Male

White

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

9326

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>9810 Summit Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Electa</u> Last <u>Middleton</u>				4. DATE OF DEATH Month <u>August</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 24, 1899</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David Sloat</u>				14. MOTHER'S MAIDEN NAME <u>Mary Miner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Glenn A. Middleton</u> Address <u>Kensington, Md. 9810 Summit Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a) <u>  </u> (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 18, 1959</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
22d. LOCATION (City, town or county) (State) <u>Silver Spring, Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Haffell</u>				ADDRESS <u>475-4-211</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

DATE SIGNED

8-15-59

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9332

1. NAME OF DECEASED _____		2. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
3. AGE _____		4. RACE _____	
5. DATE OF DEATH _____		6. TIME OF DEATH _____	
7. PLACE OF DEATH _____		8. COUNTY _____	
9. OCCUPATION _____			
10. CAUSE OF DEATH _____			
11. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined			
12. SIGNATURE OF EXAMINER _____			
13. DATE OF EXAMINATION _____			
14. SIGNATURE OF REGISTRAR _____			
15. DATE OF REGISTRATION _____			

13

9327

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mississippi</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Biloxi</b> 61X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Route 2, Box 619</b>			
3. NAME OF DECEASED (Type or print) First <b>Janet</b> Middle <b>Ruth</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>August</b> Day <b>24</b> , Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 29, 1957</b>		9. AGE (In years last birthday) yrs. <b>1</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Carl J. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Jean Sutton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage into Abdominal Tumor</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Wilm's Tumor of Right Kidney</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>36 Hours</b> <b>4 Months</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>59</b> , to <b>August 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 24</b> , 19 <b>59</b> , and that death occurred at <b>5:50 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard C. Mechanic</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>RICHARD C. MECHANIC, M.D.</b>				DATE SIGNED <b>8-25-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>		22b. DATE THEREOF <b>8/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Quitman, Mississippi</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>AUG 26 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9328

## CERTIFICATE OF DEATH

Reg. Dist. No.

09284

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>47X-3</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D. C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MO PINE NURSING HOME</b>		d. STREET ADDRESS <b>1515 2404 ST. SE</b>	
3. NAME OF DECEASED (Type or print) First <b>Louise</b> Middle <b>J.</b> Last <b>Mitchell</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 12-1883</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <b>7</b> Days <b>23</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY C. Lehmann</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Nursing Home Records</b>		Address <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis Cerebri</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>3-4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Heart</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Run</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bethesda Post and</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 1, 1959</b> to <b>Aug 23, 1959</b> , that I last saw the deceased alive on <b>Aug 23, 1959</b> , and that death occurred at <b>9:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William H Killax</b>		ADDRESS (Street, city or town, state) <b>9902 A Cambridge Rd Bethesda 18 Md</b>	
PHYSICIAN'S NAME (Type) <b>William H Killax</b>		DATE SIGNED <b>Aug 20 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Landover Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sammons Bros.</b>		24a. REC'D BY REGISTRAR <b>1661-6000 Hope Rd SE Wash DC</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		DATE <b>AUG 25 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1.2.2.2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09285

9217

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>		d. STREET ADDRESS <u>Y.F. 10F. Norwich Road.</u>	
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Frances</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1929</u>
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Daniel Moore</u>		14. MOTHER'S MAIDEN NAME <u>Connie Jean Drayton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>M. Blaser</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 10</u> , 19 <u>59</u> , to <u>Aug. 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 10</u> , 19 <u>59</u> , and that death occurred at <u>7:15p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>927 Pershing Drive Silver Spring Md.</u> DATE SIGNED <u>8/10/59</u>			
ACTUAL SIGNATURE <u>Winston E. Cochran</u>		M.D. <u>(same)</u>	
PHYSICIAN'S NAME (Type) <u>WINSTON E. COCHRAN, M.D.</u>		(same)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Pleasant Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Butler Walters</u>		ADDRESS <u>254 Carroll St</u>	
24a. REC'D BY REGISTRAR <u>J. D. Jones</u>		24b. REGISTRAR'S SIGNATURE <u>J. D. Jones</u>	
DATE <u>8-11-59</u>			

VS A15 (4)  
15M 9/55

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AUG 13 '59

Curtis L. Kraus



## CERTIFICATE OF DEATH

Reg. Dist. No.

9286

9218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Morrison</b>		4. DATE OF DEATH Month Day Year <b>August 23 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 22 1959</b>
9. AGE (In years last birthday) yrs. <b>19</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Billy Ray Morrison</b>		14. MOTHER'S MAIDEN NAME <b>Natalie Elizabeth Stewart</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>father</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage</b> <b>760.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Cause undetermined</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>17 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/22/59</b> , 19 <b>59</b> , to <b>8/23/59</b> , that I last saw the deceased alive on <b>8/22/59</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Russell B. Arnold</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>8801 Colesville Road, Silver Spring, Md. 8/23/59</b>	
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D.</b>		<b>Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>8-25-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital</b>	22d. LOCATION (City, town, or county) (State) <b>Takoma Park, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		24a. REC'D BY REGISTRAR <b>Washington Sanitarium and Hospital, Takoma Park, Maryland</b>	

2075191XV4

SEP 3 '59

Arthur S. Fries

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Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS - Thurs 26</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>103 CALVERT ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES OTIS MORTON</u>		4. DATE OF DEATH Month Day Year <u>8 6 19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INTERNAL REVENUE</u>	
11. BIRTHPLACE (State or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS J. MORTON</u>		14. MOTHER'S MAIDEN NAME <u>MARY HAZEL WOOD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>MAE P. MORTON (WIFE) SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> 451X DUE TO <u>Ruptured abdominal Aneurysm</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 3, 19 59</u> to <u>Aug. 5, 19 59</u> , that I last saw the deceased alive on <u>Aug. 5, 19 59</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Bowditch Hunter</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Veirs Mill Road</u> DATE SIGNED <u>8/6/59</u>	
PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter</u>		<u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lynon Wheeler</u> ADDRESS <u>Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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1

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

00523

CENTRAL AIR CONDITIONING

8332

1



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Damascus</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>26023 Mt. Vernon Ave.</b>		d. STREET ADDRESS <b>26023 Mt. Vernon Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Eleanor Hyatt Moxley</b>		4. DATE OF DEATH Month Day Year <b>August 17 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kempton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eli Hyatt</b>		14. MOTHER'S MAIDEN NAME <b>Georganna Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Carl A. Cline, Monrovia, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>2 days</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/16</b> , 19 <b>46</b> , to <b>8/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Kerr</b>		ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>8/18/59</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug. 20, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Meth.</b>	22d. LOCATION (City, town, or county) (State) <b>Clagettsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edwin L. Moxley</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 20 '59</b>	
ADDRESS <b>Damascus, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9331

CERTIFICATE OF DEATH

09289

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>20 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>2200 Woodfield Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Sue</u> Middle <u>Ann</u> Last <u>Mullineaux</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>19 59</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8.22.59</u>	9. AGE (In years last birthday) yrs. <u>8</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Aubrey Purdum Mullineaux, Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lee Gladhill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Cystitis</u> 762.5 DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u> <u>16 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/22</u> , 19 <u>59</u> , to <u>8/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/23</u> , 19 <u>59</u> , and that death occurred at <u>6:30</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James P. Kerr</u>				ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>		DATE SIGNED <u>8/23/59</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr, M. D.,</u>				<u>Damascus, Md.</u>		<u>8.23.9</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Damascus, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohrman</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

2073241XV3

CERTIFICATE OF DEATH

9381

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

REPORTED BY: [illegible]

DATE OF REPORT: [illegible]

Signature: [illegible]

1

9332

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cabin John</b> d. STREET ADDRESS <b>6528 79th Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Aloysius</b> Middle <b>(none)</b> Last <b>Neidert</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 25, 1906</b>	9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>August Neidert</b>			14. MOTHER'S MAIDEN NAME <b>Mary Elm</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Collapse</b> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Myelocytic Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>1 1/2 Months</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 29</b> , 19 <b>59</b> , to <b>August 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 5</b> , 19 <b>59</b> , and that death occurred at <b>4:45 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/6/59</b> NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b>		M.D. <b>The Clinical Center</b>					
PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda 14, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









CERTIFICATE OF DEATH

MAHARAJA STATE DEPARTMENT OF HEALTH-BANGALORE, 18

Form No. 1

NAME OF DECEASED <i>James M. Williams</i>		AGE <i>45</i>		SEX <i>Male</i>		DATE OF BIRTH <i>1910</i>		PLACE OF BIRTH <i>USA</i>		NATIONALITY <i>American</i>	
DATE OF DEATH <i>1955</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Respiratory failure</i>		MANNER OF DEATH <i>Natural</i>		MEDICAL ATTENDANCE <i>Yes</i>	
DISEASE OR INJURY <i>Chronic bronchitis</i>		DURATION OF DISEASE <i>10 years</i>		TREATMENT <i>Medical</i>		PREVIOUS ILLNESS <i>Yes</i>		PREVIOUS SURGERY <i>No</i>		PREVIOUS TRAUMA <i>No</i>	
SIGNATURE OF DECEASED <i>James M. Williams</i>		SIGNATURE OF WITNESS <i>John M. Williams</i>		SIGNATURE OF MEDICAL ATTENDANT <i>Dr. J. M. Williams</i>		SIGNATURE OF REGISTRAR <i>Dr. J. M. Williams</i>		SIGNATURE OF DEPUTY REGISTRAR <i>Dr. J. M. Williams</i>		SIGNATURE OF CLERK <i>Dr. J. M. Williams</i>	
DATE OF SIGNATURE <i>1955</i>		DATE OF SIGNATURE <i>1955</i>		DATE OF SIGNATURE <i>1955</i>		DATE OF SIGNATURE <i>1955</i>		DATE OF SIGNATURE <i>1955</i>		DATE OF SIGNATURE <i>1955</i>	

MAHARAJA STATE DEPARTMENT OF HEALTH-BANGALORE, 18

9333

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG248 9-16-59 et

## CERTIFICATE OF DEATH

09292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>9 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>2627 WEISSMAN ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>BROWN</b> Last <b>NICHOLSON</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>27</b> Year <b>19 59</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/88 4/18/89 11/70</b>	9. AGE (In years last birthday) yrs. <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			
13. FATHER'S NAME <b>WILLIAM H. NICHOLSON</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE YOUNG</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA WITH ABSCESS FORMATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF LUNGS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>AUGUST 18</b> , 19 <b>59</b> , to <b>AUGUST 27</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>AUGUST 26</b> , 19 <b>59</b> , and that death occurred at <b>12:07A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SANDY SPRING, MARYLAND</b> DATE SIGNED							
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type) <b>J. W. BIRD, M. D.</b>		M.D. <b>SANDY SPRING, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Aug 29 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Salem</b>		22d. LOCATION (City, town, or county) (State) <b>Brookville Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 3 '59</b>		24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9334

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 3 Film G246 8-17-59 et  
CERTIFICATE OF DEATH

09293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GERMDN TOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARYLANDER NURSING HOME</b>		d. STREET ADDRESS <b>2205 California St., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>KE TURA H</b> Middle <b>FOULDS</b> Last <b>O'BRIEN</b>		4. DATE OF DEATH Month <b>8</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) <b>OHIO</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK FOULDS</b>	
14. MOTHER'S MAIDEN NAME <b>MARY BLAIR</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>COL. ROBERT E. O'BRIEN, JR., ROSWELL, N.M.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>10 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/1/59</b> to <b>8/13/59</b> , that I last saw the deceased alive on <b>8/12/59</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Kerr</b>		ADDRESS (Street, city or town, state) <b>DAMASCUS, Md.</b> DATE SIGNED <b>8/13/59</b>	
PHYSICIAN'S NAME (Type) <b>James G. Kerr</b>		<b>DAMASCUS M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/17/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>FORT MYER, VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Charles Smith</b>		24a. REC'D BY REGISTRAR <b>1756 Pa. Ave., N.W. DC</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>



10

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**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9335**  
**CERTIFICATE OF DEATH**

09294

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>37 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville 26</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>5 Shetland Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Nancy</b> Last <b>Oliverio</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1959</b>		9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 14, 1905</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Leon Casella</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Reale</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Adenocarcinoma, Liver</b> DUE TO (c) <b>Adenocarcinoma, Sigmoid Colon</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>1 year</b>  <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypercholesterolemia</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 7, 1959</b> , to <b>August 13, 1959</b> , that I last saw the deceased alive on <b>August 13, 1959</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 8-14-59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Charles E. Mengel</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Charles E. Mengel, M. D.</b>							
22a. BURIAL, CREMATION, 22b. DATE THEREOF <b>Burial-transit 8-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>Aug 18 59</b>		24b. REGISTRAR'S SIGNATURE <b>Robert A. Humphrey</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9336

## CERTIFICATE OF DEATH

Reg. Dist. No.

09295

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Pastre</u>		4. DATE OF DEATH Month Day Year <u>AUG. 23 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 18 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ADVANCED CEREBRAL VASCULAR ARTERIOSCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days - 10 YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC PYELONEPHRITIS; PROSTATIC HYPERTROPHY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>55</u> , to <u>Aug 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug. 23</u> , 19 <u>59</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>9420 OLD GEORGETOWN RD 23 Aug 1959</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR MD</u>		<u>BETHESDA 14 MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>8/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bergen County, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kraus</u>	

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

04-20

INSTITUTE OF DEATH

0330

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "INSTITUTE OF DEATH" and "0330" are visible.]*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film G247 8-27-59 et

9337

CERTIFICATE OF DEATH

09296

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md-Montgomery</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>9205 Burley Dr</u>			
3. NAME OF DECEASED (Type or print) First <u>Millard</u> Middle <u>E</u> Last <u>Peake</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-14-85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u>		11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laingman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Joseph Millard Peake</u>				14. MOTHER'S MAIDEN NAME <u>Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-03-6700</u>		INFORMANT Address <u>Agnes L. Peake-Same Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Failure</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 1948, to <u>Aug 21</u> , 1957, that I last saw the deceased alive on <u>Aug 21</u> , 1959, and that death occurred at <u>12:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.B. Wardrop MD</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>8/21/59</u>			
PHYSICIAN'S NAME (Type) <u>W.B. WARDROP MD</u>				<u>837 Bonjour St. Silver Spring MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

85200

3337

CERTIFICATE OF DEATH

857-03-0700 Agency, Baltimore Item 42

Robert A. Kennedy, Bethesda, Maryland  
8/24/1960  
Rockville Cemetery, Rockville, Maryland



9338

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>40 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Franklin</b> Last <b>PETERSON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-24-12</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Kansas</b>	
13. FATHER'S NAME <b>Frank PETERSON</b>				14. MOTHER'S MAIDEN NAME <b>Hattie MOON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>546 30 1102</b>		INFORMANT <b>(W) Mrs. Anna S. Peterson, same address as #2</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 3</b> , 19 <b>59</b> , to <b>August 3</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 3</b> , 19 <b>59</b> , and that death occurred at <b>10:00 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-4-59</b>							
ACTUAL SIGNATURE <b>J. M. Young</b> M.D. <b>U. S. Naval Hospital</b>				DATE SIGNED <b>8-4-59</b>			
PHYSICIAN'S NAME (Type) <b>J. M. YOUNG, LT, MC, USN</b>				Bethesda 14, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Pumphrey Funeral Home, 8434 Ga. Ave., SS, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 7 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. E. House</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(1992) 105-110.

120520

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1

9339

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09298

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>505 Marshall Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Bruce</b> Middle <b>Wade</b> Last <b>PETTIJOHN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-51</b>	9. AGE (In years last birthday) <b>7</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jack E. PETTIJOHN</b>				14. MOTHER'S MAIDEN NAME <b>Freda May GARNETT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(F) Jack E. Pettijohn, same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>591X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>nephrosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>2 1/2 years</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>July 25</b> , 19 <b>59</b> , to <b>August 4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 4</b> , 19 <b>59</b> , and that death occurred at <b>12:20AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. De Paola</b>		M.D. <b>U. S. Naval Hospital</b>		DATE SIGNED <b>8-4-59</b>			
PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b>		ADDRESS <b>Bethesda, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>Tyson Wheeler Funeral Home, Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 7 59</b> DATE		24b. REGISTRAR'S SIGNATURE <b>William S. Travis</b>	

8888

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

SEX OF DECEASED

AGE OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

NEW YORK

STATE OF NEW YORK

DATE OF DEATH

(7) DATE OF DEATH

TIME

NO.

DATE

NO.

DATE

DATE OF DEATH

DECEASED

DATE OF DEATH

5.

DATE

DATE OF DEATH

DATE

DATE

DATE OF DEATH

FOR STATE  
HEALTH DEPT.

9340

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09299

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>1 week</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11,711 GALT AVENUE</b>				d. STREET ADDRESS <b>8405 DIXON AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH LEE PHAUP</b>				4. DATE OF DEATH Month <b>AUGUST 24,</b> Day <b>19</b> Year <b>59</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/71</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress (alterations)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store Clothing stores</b>		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MERRITT</b>				14. MOTHER'S MAIDEN NAME <b>MARY OWEBY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>yes</b>		17. INFORMANT Address <b>Mrs. Blanche L. Moore, 11,711 Galt Ave. Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arterio-sclerosis</b> DUE TO (c) <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





9341

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09300

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN <u>Suburban Hospital</u> c. LENGTH OF STAY IN 1b <u>1</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Suburban Hospital, Bethesda #7-Therman Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>SELENA LAURA PHIPPS</u>			4. DATE OF DEATH <u>August 17 1959</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15-1969</u>	9. AGE (In years last birthday) <u>90</u> yn.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. BIRTHPLACE (State or foreign country) <u>New York -</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Peter Walters</u>			14. MOTHER'S MAIDEN NAME <u>Edna Harvey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT <u>Miss Hilda Phipps #7 Therman Ave.</u>			Address <u>Sak. Park</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>age (90 yrs)</u> DUE TO (c) <u>Adreno-Cortical / Colon - Intestinal Obst.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u> <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Aug 17</u> , 19 <u>59</u> , to <u>Aug 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James H Scully</u> M.D.			ADDRESS (Street, city or town, state) <u>1835 Eye St NW</u>		
PHYSICIAN'S NAME (Type) <u>JAMES H SCULLY</u>			DATE SIGNED <u>Aug 16 D.C.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sak. Park Cemetery</u>	
22d. LOCATION (City, town, or county) (State)		22e. LOCATION (City, town, or county) (State) <u>Riggs Road Prince Georges Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW</u>			24a. REC'D BY REGISTRAR <u>Aug 21 '59</u>		
ADDRESS			24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>		

0345

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]		TIME OF BIRTH [Faint handwritten time]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
PLACE OF DEATH [Faint handwritten place]		DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
CITY [Faint handwritten city]		COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

0345

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

0345

1  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9342

Item 16 Film G248 9-3-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

09301

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Florida</b> b. COUNTY <b>Pineallasy</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Petersburg</b> 48 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3522 Raymond Street-</b>		d. STREET ADDRESS <b>1227 James Avenue, South</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>L.</b> Last <b>PIERCE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/1884</b>
9. AGE (In years last birthday) <b>74</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>16</b>	
IF UNDER 24 HRS. Hours <b>11</b> Min. <b>16</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>246-07-1531</b>	
17. INFORMANT <b>Magnolia E. Pierce-wife-same as item 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Antero-lateral myocardial infarction.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>coronary atherosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/14</b> , 19 <b>59</b> , to <b>Aug 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/14</b> , 19 <b>59</b> , and that death occurred at <b>1:45 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ ACTUAL SIGNATURE <b>Arron Schwartzman</b> M.D. DATE SIGNED <b>8/17/59</b> PHYSICIAN'S NAME (Type) <b>Dr. Arron Schwartzman, 2007 Nichols Ave. S.E. Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE <b>AUG 18 '59</b>	

1930

STATE OF OHIO  
DEPARTMENT OF HEALTH

3342

REPORT OF DEATH

1930

DECEASED

REPORTER

DECEASED'S NAME

DECEASED'S ADDRESS

DECEASED'S AGE

SEX

RACE

DATE

TIME

PLACE

CAUSE

MANNER

LOCATION

DATE

1

DECEASED'S NAME

CAUSE

MANNER

LOCATION

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TIME

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LOCATION

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TIME

PLACE

DECEASED'S NAME

MANNER

LOCATION

DATE

TIME

PLACE

9220

## CERTIFICATE OF DEATH

Reg. Dist. No.

09302

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRA DRYDEN PITTENGER</u>				4. DATE OF DEATH Month Day Year <u>AUG. 17 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-8-76</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MO.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMER.</u>							
13. FATHER'S NAME <u>William H. Pittenger</u>				14. MOTHER'S MAIDEN NAME <u>Maria Dryden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Washington Sanitarium &amp; Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burchgumian</u> <u>446X</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis</u> (c) <u>Renal insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal insufficiency</u> INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>yes</u> <u>yes</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/14</u> , 19 <u>59</u> , to <u>8/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u> DATE SIGNED <u>John A. Wolohin</u> ACTUAL SIGNATURE <u>John A. Wolohin</u> M.D. PHYSICIAN'S NAME (Type) <u>Chas. H. Wolohin</u> <u>Takoma Park, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 19, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St WDC</u>				24. REC'D BY REGISTRAR DATE <u>AUG 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. ...</u>	

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



08302

CERTIFICATE OF DEATH

08302

1



9343

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G246 8-24-59 et

## CERTIFICATE OF DEATH

09303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Manda C Plummer</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/19/88 1879</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Hazel W Cashell</b>		14. MOTHER'S MAIDEN NAME <b>Mary E Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>M. Elizabeth Plummer - daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UREMIA</b> DUE TO (c) <b>HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>2 DAYS</b> <b>20 YEARS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRILLIANT FIBRILLATION - NEPHRO-SCLEROSIS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 17, 1959</b> to <b>August 17, 1959</b> , that I last saw the deceased alive on <b>August 17, 1959</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.		ADDRESS (Street, city or town, state) <b>26 N. Summit Ave. Gaithersburg, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>		DATE SIGNED <b>Aug 19 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/20/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler-1331 E. Montgomery Ave. Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 19 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. The low requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9343

Mrs. C. F. Thomas

M. Knight Thomas

## CERTIFICATE OF DEATH

Reg. Dist. No.

9221

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON SAN. &amp; HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANK</b> First <b>SALES</b> Middle <b>POTANKA</b> Last <b>SR</b>				4. DATE OF DEATH <b>Aug 26 1959</b> Month Day Year			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/29/91</b>	
9. AGE (In years lost birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner &amp; Pres. Auto Dealer, Pohanka Serv. Inc.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NEW YORK</b>			
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JULIUS POHANKA</b>				14. MOTHER'S MAIDEN NAME <b>ERNESTINE VOLYEAR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>578-40-9720</b>			
17. INFORMANT <b>Mrs. Charlotte M. Pohanka</b>				Address <b>428 Jarboe Ave. Burnt Mills Hills, Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral embolism with infarction of brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atherosclerosis of aorta</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recent coronary thrombosis with infarction</b>				INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b> <b>5 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>12-1</b> , 19 <b>59</b> to <b>8-26</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Aug 26</b> , 19 <b>59</b> , and that death occurred at <b>12:35 P.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas. W. Harnsberger</b> M.D.				ADDRESS (Street, city or town, state) <b>4201 New Hampshire NW</b>			
PHYSICIAN'S NAME (Type) <b>CHAS. W. HARNSEBERGER</b>				DATE SIGNED <b>8/26/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>8/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>			
24a. REC'D BY REGISTRAR <b>Arthur E. Hines</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

9344 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09305

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Indiana</b> b. COUNTY <b>Marion</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN lb <b>3 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8100 Beechtree Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEORA</b> Middle <b>H.</b> Last <b>POLLEY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>12,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1871</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Mathew Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Bryan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Daughter</b> <b>Nellie Polley Jackson</b>		Address <b>Same as Item#1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Congestive heart failure</b> DUE TO (c) <b>Arterio Sclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>4+ yrs</b> <b>10+ years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTHRITIS, RHEUMATOID</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/29</b> , 19 <b>59</b> to <b>8/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/12</b> , 19 <b>59</b> , and that death occurred at <b>5:15</b> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4090 Battery Lane</b> DATE SIGNED <b>9/17/59</b> ACTUAL SIGNATURE <b>Charles Savarese</b> M.D. PHYSICIAN'S NAME (Type) <b>CHARLES SAVARESE, JR.</b> Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 8-13-59</b>		22b. DATE THEREOF <b>8-13-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion County, Indiana</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY,</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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## CERTIFICATE OF DEATH

Item 9 Film 247 8-28-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Carroll</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>3 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster 06x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS <u>1ste #4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Tennessee</u> Last <u>Powers</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 6 1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Elihu Counts</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Sutherland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Lucille Bell 504 Fletcher Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Aug 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>59</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herman Chiofanzini</u>				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd</u>		DATE SIGNED <u>8/21/59</u>	
PHYSICIAN'S NAME (Type) <u>Herman Chiofanzini</u>				<u>Rockville Ind.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 23 '59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RUSSELL MEMORIAL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>LEBANON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SAFFELL</u> ADDRESS <u>FUNERAL HOME - WESTMINSTER MD.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Lewis</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9345

CERTIFICATE OF DEATH

Reg. Dist. No.

09307

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RD 2, Gaithersburg</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RD 2, Gaithersburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Susie</i> First <i>Valinda</i> Middle <i>Prather</i> Last		4. DATE OF DEATH <i>8</i> Month <i>1</i> Day <i>19-59</i> Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 10, 1884</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Hess Washington</i>		14. MOTHER'S MAIDEN NAME <i>Valinda Disney</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. William Prather</i> HUSBAND Address <i>RD 2, Gaithersburg</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension</i> DUE TO (c) <i>Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i> <i>3 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility, Incontinence</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 1956</i> to <i>Aug. 1, 1959</i> , that I last saw the deceased alive on <i>July 31, 1959</i> , and that death occurred at <i>5 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clive E. Jackson</i>		DATE SIGNED <i>RD 1, Gaithersburg, Md. 8-1-59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/5/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brooke Grove</i>	22d. LOCATION (City, town, or county) (State) <i>Laytonsville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Suroder</i> ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR <i>AUG 5 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9345 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09308

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 1 hr 10 min</u> c. LENGTH OF STAY IN 1b. <u>Washington 47 x -3</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u> e. STREET ADDRESS <u>621 8th Street N.E.</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Jane</u> Last <u>Price</u>		<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>10</u> Year <u>1959</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>C.</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>4-2-1912</u>
<b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housework</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Harrison Timberlake</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lula Rogland</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>	
<b>17. INFORMANT</b> <u>Marshall Timberlake</u> (Address <u>608-7th St NW</u> )		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Intracerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Rupture Left Main Striate Artery, Left</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>		<b>DATE SIGNED</b> <u>8-11-59</u>	
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>	<b>22b. DATE THEREOF</b> <u>8-14-1959</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Memorial</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Suitland Md</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Spangler</u>		<b>24a. REC'D BY REGISTRAR</b> <u>524-8th St NE</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>William S. Spangler</u>		<b>24c. REGISTRAR'S SIGNATURE</b> <u>William S. Spangler</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Page No. 100

1. Name of Deceased: *William J. Smith*  
2. Date of Death: *April 18, 1935*  
3. Place of Death: *Home*  
4. Age: *48*  
5. Sex: *Male*  
6. Race: *White*  
7. Occupation: *Teacher*  
8. Cause of Death: *Myocardial Infarction*  
9. Manner of Death: *Natural*  
10. Signature of Examiner: *W. J. Smith*

11. Signature of Physician		12. Signature of Coroner	
13. Signature of Medical Examiner		14. Signature of Registrar	
15. Signature of Undertaker		16. Signature of Burial Place	
17. Signature of Funeral Home		18. Signature of Cemetery	
19. Signature of Mortuary		20. Signature of Interment	
21. Signature of Burial		22. Signature of Cremation	
23. Signature of Disposition		24. Signature of Other	
25. Signature of Final		26. Signature of Record	
27. Signature of Certificate		28. Signature of Death	
29. Signature of Burial		30. Signature of Cremation	
31. Signature of Disposition		32. Signature of Other	
33. Signature of Final		34. Signature of Record	
35. Signature of Certificate		36. Signature of Death	
37. Signature of Burial		38. Signature of Cremation	
39. Signature of Disposition		40. Signature of Other	
41. Signature of Final		42. Signature of Record	
43. Signature of Certificate		44. Signature of Death	
45. Signature of Burial		46. Signature of Cremation	
47. Signature of Disposition		48. Signature of Other	
49. Signature of Final		50. Signature of Record	
51. Signature of Certificate		52. Signature of Death	
53. Signature of Burial		54. Signature of Cremation	
55. Signature of Disposition		56. Signature of Other	
57. Signature of Final		58. Signature of Record	
59. Signature of Certificate		60. Signature of Death	
61. Signature of Burial		62. Signature of Cremation	
63. Signature of Disposition		64. Signature of Other	
65. Signature of Final		66. Signature of Record	
67. Signature of Certificate		68. Signature of Death	
69. Signature of Burial		70. Signature of Cremation	
71. Signature of Disposition		72. Signature of Other	
73. Signature of Final		74. Signature of Record	
75. Signature of Certificate		76. Signature of Death	
77. Signature of Burial		78. Signature of Cremation	
79. Signature of Disposition		80. Signature of Other	
81. Signature of Final		82. Signature of Record	
83. Signature of Certificate		84. Signature of Death	
85. Signature of Burial		86. Signature of Cremation	
87. Signature of Disposition		88. Signature of Other	
89. Signature of Final		90. Signature of Record	
91. Signature of Certificate		92. Signature of Death	
93. Signature of Burial		94. Signature of Cremation	
95. Signature of Disposition		96. Signature of Other	
97. Signature of Final		98. Signature of Record	
99. Signature of Certificate		100. Signature of Death	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9347 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3316 Jones Bridge Rd</u>				d. STREET ADDRESS <u>3316 Jones Bridge Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>malcolm</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-1934</u>	
9. AGE (In years last birthday) <u>25 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>gas station</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Thomas M. Price</u>			
14. MOTHER'S MAIDEN NAME <u>Evalyn Beta Town</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT Name <u>Heather Price (wife)</u> Address <u>Stn 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound in rt skull</u> DUE TO (c) <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>976x</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in rt temple</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a. m. <u>pm</u> <u>8-17</u> <u>1959</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Bethesda</u>				(County) <u>Montg</u>		(State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>8-17-59</u>			
22a. BURIAL, CREMATION, or other disposition <u>Cremation</u>		22b. DATE THEREOF <u>8/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

## 1030

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9348 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">Montgomery</div> <div style="text-align: center;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <div style="text-align: center;">D.C.</div> <div style="text-align: center;">b. COUNTY</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Bethesda</div>		c. LENGTH OF STAY IN 1b <div style="text-align: center;">7hrs</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center;">Sisters of Mercy, Kendall Rd.</div>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Washington</div> <div style="text-align: right;">47X-3</div>	
f. STREET ADDRESS <div style="text-align: center;">1508 14th St., N.W.</div>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">Charles Henry Reaves</div>		4. DATE OF DEATH Month <div style="text-align: center;">Aug.</div> Day <div style="text-align: center;">3,</div> Year <div style="text-align: center;">1959</div> <div style="text-align: right;">19</div>	
5. SEX <div style="text-align: center;">male</div>		6. COLOR OR RACE <div style="text-align: center;">col.</div>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center;">Sept 7, 1918</div>	
9. AGE (In years last birthday) <div style="text-align: center;">40</div> yrs.		10. IF UNDER 1 YEAR Months <div style="text-align: center;">40</div> Days <div style="text-align: center;">0</div> Hours <div style="text-align: center;">0</div> Min. <div style="text-align: center;">0</div>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">laborer</div>		12. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">Va.</div>	
13. BIRTHPLACE (State or foreign country) <div style="text-align: center;">USA</div>		14. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">USA</div>	
15. FATHER'S NAME <div style="text-align: center;">Marshall Reaves</div>		16. MOTHER'S MAIDEN NAME <div style="text-align: center;">Lilly Jones</div>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <div style="text-align: center;">(If yes, give war or dates of service)</div>		18. SOCIAL SECURITY NO. <div style="text-align: center;">Louis Reaves</div>	
19. INFORMANT <div style="text-align: center;">Louis Reaves</div>		20. ADDRESS <div style="text-align: center;">1637 11st., N.W. Wash. D.C.</div>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="text-align: center;">Coronary occlusion</div> <div style="text-align: center;">420.1</div> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <div style="text-align: center;">sudden</div> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <div style="text-align: center;">19</div> o. m. <div style="text-align: center;">p. m.</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <div style="text-align: center;">Frank J. Broschart</div>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <div style="text-align: center;">Frank J. Broschart</div>		DATE SIGNED <div style="text-align: center;">8/3/59</div>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		22b. DATE THEREOF <div style="text-align: center;">8-8-59</div>	
22c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Church</div>		22d. LOCATION (City, town, or county) (State) <div style="text-align: center;">Bullesboro Va</div>	
23. FUNERAL DIRECTOR'S SIGNATURE <div style="text-align: center;">District Mortician</div>		24a. REC'D BY REGISTRAR DATE <div style="text-align: center;">9-4-59</div>	
24b. REGISTRAR'S SIGNATURE <div style="text-align: center;">John D. Watson</div>		24c. REGISTRAR'S SIGNATURE <div style="text-align: center;">Arthur S. King</div>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

AUG 6 '59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation.

VS. A15ME(5)

SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10493

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		1d. STREET ADDRESS <i>12104 Grandview Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>John D Rees</i>		4. DATE OF DEATH <i>8 12 1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 28 1933</i>
9. AGE (In years last birthday) <i>26</i> yrs.		IF UNDER 1 YEAR <i>6</i> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lineman A Potomac Power Co. Md.</i>		11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>	
13. FATHER'S NAME <i>John David Rees</i>		14. MOTHER'S MAIDEN NAME <i>Frances Alberta Glotfelty</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>577-42-8205</i>	
17. INFORMANT <i>Jean Rees</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 902.5 DUE TO <i>Ventricular Fibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <i>Electric Shock</i> (c) <i>Electric Shock</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <i>Fall from P. E. Co. pole</i>	
20c. TIME OF INJURY Month, Day, Year <i>8-12 1959</i> Hour <i>3:30</i> a.m. <i>p.m.</i>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Wake Rd</i>	20f. (City or town) <i>Kensington Md</i> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Boeschant</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. BOESCHANT</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>8-13-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>8/17/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A Ziska</i> ADDRESS <i>ARNER E. PUMPHREY, INC. SILVER SPRING, MD.</i>		24a. REC'D BY REGISTRAR <i>AUG 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MEDICAL CERTIFICATE

15

2

or removal.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
9349									
CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>325 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5443 Alta Vista Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Terry</b> Last <b>REINICHE</b>					4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-29-56</b>		9. AGE (In years last birthday) <b>2</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Harvey Terry REINICHE</b>					14. MOTHER'S MAIDEN NAME <b>Lois LIVESAY</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>(F) Harvey T. Reiniche, same as #2 above.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>aplastic anemia</b> <b>292.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 30</b> , 19 <b>58</b> , to <b>August 21</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 21</b> , 19 <b>59</b> , and that death occurred at <b>7:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Howard A. Pearson</b> M.D. <b>U. S. Naval Hospital</b> <b>8-21-59</b> PHYSICIAN'S NAME (Type) <b>Howard A. PEARSON, LT, MC, USN</b> <b>Bethesda 14, Maryland</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b> ADDRESS <b>R.A. Pumphrey Funeral Home, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

91812

0342

CERTIFICATE OF DEATH

NAME OF DECEASED: TERRY, TERRY

DATE OF DEATH: 12-27-54

PLACE OF DEATH: U.S. Naval Hospital

Cause of Death: Myocardial Infarction

Time of Death: 11:00 AM

Signature of Physician: [Signature]

Signature of Medical Examiner: [Signature]

Signature of Coroner: [Signature]

DATE OF BIRTH: 12-27-54

AGE: 21

PLACE OF BIRTH: U.S. Naval Hospital

DATE OF DEATH: 12-27-54

Signature of Coroner: [Signature]

Signature of Medical Examiner: [Signature]

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and to any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9350

CERTIFICATE OF DEATH

Reg. Dist. No.

09313

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS <b>4527 Avondale St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Roberta</b> Middle <b>Jane</b> Last <b>Riley</b>		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/70</b>
9. AGE (In years last birthday) <b>89</b>		IF UNDER 1 YEAR <b>0</b> Months <b>0</b> Days IF UNDER 24 HRS. <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>XXXXXX Henson Ricketts</b>		14. MOTHER'S MAIDEN NAME <b>Martha XXXXXXXXXX Carlisle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Helew Roberta Bodmer - daughter</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE - 23 - 1959</b> to <b>AUG - 14 - 1959</b> , that I last saw the deceased alive on <b>AUG - 14 - 1959</b> and that death occurred at <b>7-19-59 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William C. Miller</b>		ADDRESS (Street, city or town, state) <b>7-Brooks Ave., Gaithersburg, Md</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM C. MILLER</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/18/59</b>	
22c. NAME OF CEMETERY OR CREMATOR <b>Darnestown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Darnestown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pennington</b>		24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Continued of Answer

Answer

William C. Miller  
William C. Miller  
2-Brooks Ave. 1  
Baltimore, Md.  
Aug-14-02  
June-22-02  
Aug-14-02

9233

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Stephen</b> Last <b>Rinker</b>		4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/28/83</b>
9. AGE (In years last birthday) yrs. <b>75</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>28</b> Hours <b>19</b> Min. <b>59</b>	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>28</b> Hours <b>19</b> Min. <b>59</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MAIL MAN</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ALVIN RINKER</b>	
14. MOTHER'S MAIDEN NAME <b>ELLAMAND FRACK</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Sanitarium Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 22</b> , 19 <b>59</b> , to <b>Aug 28</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Aug 26</b> , 19 <b>59</b> , and that death occurred at <b>12:00 Noon</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Benjamin Isaacson</b> M.D. <b>7733 Alaska Ave. N.W. 8/28/59</b> <b>Washington, D.C., Wash., D.C.</b>			
ACTUAL SIGNATURE <b>BENJAMIN ISAACSON</b>		PHYSICIAN'S NAME (Type) <b>BENJAMIN ISAACSON</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HAWERTOWN, PENNA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Garbison</b>		ADDRESS <b>1736 Pa. Ave. N.W. Wash. D.C.</b>	24a. REC'D BY REGISTRAR DATE <b>AUG 31 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1925

January 15

John Doe

Male

White

1000 Main Street

City

State

Age 45

Married

Single

Occupation

Teacher

Farmer

Cause of Death

Heart Disease

Stroke

Place of Death

Home

Hospital

Signature

Physician

Coroner

Witness

Neighbor

Minister

Interment

Cemetery

Church

Remarks

None

Other



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1

9351 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

09315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	c. LENGTH OF STAY IN 1b <u>28 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOHNSTOWN</u> <u>75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>R.D.#13 BOX 179</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Nabel</u> First <u>A</u> Middle <u>ROSE</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/92</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u> Hours <u></u> Min. <u></u>	11. IF UNDER 24 HRS. Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaking</u>	11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN TAYLOR POORMAN</u>	
14. MOTHER'S MAIDEN NAME <u>EDNA FREDRESY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT Address <u>EDWARD ROSE (HUSBAND)</u> <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Cerebral Thrombosis</u> DUE TO (b) <u>Artero-sclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>8/5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/5</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Farwell</u>		ADDRESS (Street, city or town, state) <u>12126 Viers Mill Rd. Silver Spring, Md.</u> DATE SIGNED <u>8/5/1959</u>	
PHYSICIAN'S NAME (Type) <u>Charles Farwell, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Richland</u>	22d. LOCATION (City, town, or county) (State) <u>Cambria Co. Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 7 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William E. Hume</u>

04317

CERTIFICATE OF DEATH

9331

RECEIVED  
MAY 20 1918

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

12122 West Hill Rd. Silver Spring, Md.

1918

Charles Farwell, M.D.

Charles G. Farwell, Registrar

12/2/22

12122 West Hill Rd. Silver Spring, Md.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9352**  
**CERTIFICATE OF DEATH**

09316

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>18 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Montgomery</b> 40x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>1426 Good Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Theodore</b> Middle <b>Roosevelt</b> Last <b>ROWELL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-10-18</b>		9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Wesley ROWELL</b>				14. MOTHER'S MAIDEN NAME <b>Jessie D. COGBORN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1941 to DOD 419-18-8482</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hepatoma</b> DUE TO (c) <b>Cirrhosis, liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>3 mos (appr)</b>  <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 2</b> , 19 <b>59</b> , to <b>August 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 19</b> , 19 <b>59</b> , and that death occurred at <b>2:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-20-59</b>							
ACTUAL SIGNATURE <b>B.H. Rice</b>		M.D. <b>U. S. Naval Hospital</b>					
PHYSICIAN'S NAME (Type) <b>B. H. RICE, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 8-22-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.J.K.</b> ADDRESS <b>W.W.Chambers &amp; Co., 1400 Chapin St.NW, Wash. DC</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3852

1

1. Name of deceased (Print or write full name)  
John Wesley Brown

2. Sex  
Male

3. Date of birth  
1910-10-10

4. Place of birth  
U.S.A.

5. Date of death  
1960-08-15

6. Place of death  
Hospital

7. Cause of death (Print or write full name)  
Heart failure

8. Signature of medical officer  
Dr. J. H. Smith

9. Signature of registrar  
Mr. J. H. Smith

10. Date of registration  
1960-08-15

11. Name of informant  
John Wesley Brown

12. Address of informant  
123 Main Street, London, W.C.1

13. Signature of informant  
John Wesley Brown

14. Date of completion of form  
1960-08-15

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09317

9353

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SANDY SPRING</u>		LENGTH OF STAY (in this place) <u>9 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>WASHINGTON, D. C.</u> <u>47x-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SHARON NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>1644 MICHIGAN AVE., N. E.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ELVINA CLARISSA RUMBAUGH</u> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>AUGUST 12</u> <u>19 59</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>MAY 1, 1882</u>	<b>9. AGE last birthday</b> <u>77</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker (retd)</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>PENNSYLVANIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>JACOB OBEDIAH BECK</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>HARRIET NOLF</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> ( <u>N.E., WASHINGTON, DC</u> ) <u>MRS. FRED L. THOMAS, 1644 MICHIGAN AVE.,</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>334x</u> IMMEDIATE CAUSE (A) <u>Right Lymphlegia</u>						<u>Today's</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while <input type="checkbox"/> el work		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>7/7</u>, 19 <u>59</u>, to <u>8/12</u>, 19 <u>59</u>, that I last saw the deceased alive on <u>8/11</u>, 19 <u>59</u>, and that death occurred at <u>7:00</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>[Signature]</u>		<b>M.D.</b> <u>[Signature]</u>		<b>ADDRESS</b> (Street, city, town, state) <u>[Signature]</u>		<b>DATE SIGNED</b> <u>8/12/59</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>AUGUST 15, 1959</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>UNION CEMETERY</u>		<b>LOCATION</b> (City, town, or county) (State) <u>BETHEL, CRAWFORD CO., PA.</u>	
<b>24. REC'D BY REGISTRAR</b> DATE <u>AUG 14 '59</u>		<b>REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u> <u>[Signature]</u>			

10-12

# CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE	
JAMES H. HARRIS		Male		45	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
New York City		Teacher		Married	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
October 15, 1945		10:30 AM		Home	
10. CAUSE OF DEATH		11. MEDICAL OPINION		12. SIGNATURE OF PHYSICIAN	
Heart Disease		Myocardial Infarction		J. H. Smith, M.D.	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF FUNERAL HOME	
A. B. Jones		C. D. White, E. F. Green		G. H. Black	
16. DATE OF REGISTRATION		17. TIME OF REGISTRATION		18. PLACE OF REGISTRATION	
October 16, 1945		9:00 AM		Health Department	
19. SIGNATURE OF DEPUTY REGISTRAR		20. SIGNATURE OF CLERK		21. SIGNATURE OF CHIEF CLERK	
H. I. Brown		J. K. Green		L. M. White	

RECEIVED

NOTICE: This certificate is valid only if it is filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. If it is not so filed, it is invalid for all purposes. The Registrar will not accept a certificate if it is not properly filled out or if it is not signed by a physician or a funeral home. The Registrar will not accept a certificate if it is not filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, within ten days of the date of death. If it is not so filed, it is invalid for all purposes. The Registrar will not accept a certificate if it is not properly filled out or if it is not signed by a physician or a funeral home.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09318

9222

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Margherita (N.M.) Santini</u>		4. DATE OF DEATH <u>August 9 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-76</u>
9. AGE (In years, last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>John Maschio</u>		14. MOTHER'S MAIDEN NAME <u>Maria</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrotic Syndrome</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Arteriosclerosis - Senility</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1959</u> to <u>Aug 9, 1959</u> , that I last saw the deceased alive on <u>Aug 8, 1959</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		DATE SIGNED <u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 11, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CATHOLIC CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>LAUREL PRIDGEMAN CO., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Hall</u>		ADDRESS <u>WASH 13, D.C.</u>	
24a. REC'D BY REGISTRAR <u>AUG 11 1959</u>		24b. REGISTRAR'S SIGNATURE <u>William J. Hall</u>	

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9354

## CERTIFICATE OF DEATH

09319

Reg. Dist. No.

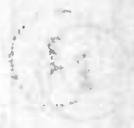
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X BROOKEVILLE</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAM -- SARGENT</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 5 19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/11/89</b>
9. AGE (In years lost birthday) <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ARTIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11. BIRTHPLACE (State or foreign country) <b>MASS.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES HENRY SARGENT</b>		14. MOTHER'S MAIDEN NAME <b>LUCY ELLEN COOCH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>7-246-1</b>	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>5 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic nephrosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15, 1959</b> , to <b>Aug 5, 1959</b> , that I last saw the deceased alive on <b>Aug 5, 1959</b> , and that death occurred at <b>1:28 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		ADDRESS (Street, city or town, state) <b>Clarksville, Md.</b>	
DATE SIGNED <b>8-5-59</b>			
PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-7-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Shirwood, Howard Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Knight</b>		ADDRESS <b>Clarksville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE AUG 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF DEATH

9355

Page 2 of 2

<p>1. NAME OF DECEASED                  [Illegible]</p>		<p>2. SEX                  [Illegible]</p>	
<p>3. AGE                  [Illegible]</p>		<p>4. DATE OF BIRTH                  [Illegible]</p>	
<p>5. PLACE OF BIRTH                  [Illegible]</p>		<p>6. DATE OF DEATH                  [Illegible]</p>	
<p>7. TIME OF DEATH                  [Illegible]</p>		<p>8. PLACE OF DEATH                  [Illegible]</p>	
<p>9. CAUSE OF DEATH                  [Illegible]</p>		<p>10. MANNER OF DEATH                  [Illegible]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Illegible]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Illegible]</p>	
<p>13. SIGNATURE OF WITNESS                  [Illegible]</p>		<p>14. SIGNATURE OF DECEASED                  [Illegible]</p>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

9355

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 Film 6249 9-29-59 et

Reg. Dist. No.

09320

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5710 Aberdeen Road</b>				d. STREET ADDRESS <b>5710 Aberdeen Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>A.</b> Last <b>Sayre</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>13</b> , Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>1907</b> <b>Feb. 14, 1906</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b>29</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Econ. Statistician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arthur Sayre</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT Address <b>Edmund Neary - Friend</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Found dead on Kitchen floor.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>Aug. 13, 1959</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>		22b. DATE THEREOF <b>8-15-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>E. Ridgelawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Delawanna, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda 14, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	







9223

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>700 Hudson Avenue EVENTIDE NURSING HOME</b>		d. STREET ADDRESS <b>6606 23rd Place</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>E.</b> Last <b>SCHLERF</b>		4. DATE OF DEATH Month <b>8</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/1873</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Filing Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Matthew Bryan</b>		14. MOTHER'S MAIDEN NAME <b>Martha J. Beall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Records at Nursing Home</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2 Congestive heart failure</b> DUE TO (b) <b>Senility</b> DUE TO (c) <b>Myocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug 1957</b> , 19____, to <b>Aug 12</b> , 19____, (that I last saw the deceased alive on <b>Aug 11</b> , 19____, and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. W. Smith</b>		ADDRESS (Street, city or town, state) <b>1821 RANDOLPH ST. N.W. WASHINGTON, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>A. W. SMITH</b>		DATE SIGNED <b>8/12/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/14/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>AUG 13 '59</b>	
ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1381

3232

1

9356

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>4803 Hampton Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Harvey</i>		First <i>Brewer</i>		Middle <i>Schwartz</i>		Last <i>Schwartz</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <i>Aug</i> Day <i>28</i> Year <i>1959</i>	
9. AGE (In years, lost birthday) yrs. <i>72</i>		10. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clark</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railway Express Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph Schwartz</i>				14. MOTHER'S MAIDEN NAME <i>Mollie Musgrove</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>714-07-2352</i>		INFORMANT <i>Mary Schwartz</i>		Address <i>Bethesda</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Myocardial insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes mellitus</i> <i>Left ureteral calculus</i> <i>Left ureterolithotomy</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/26</i> , 19 <i>59</i> , to <i>8/28</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>8/28</i> , 19 <i>59</i> , and that death occurred at <i>3:30</i> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert H. Coale</i>		M.D. <i>4630 Montgomery Ave.</i>		ADDRESS (Street, city or town, state) <i>Bethesda, Md.</i>		DATE SIGNED <i>8/29/59</i>	
PHYSICIAN'S NAME (Type) <i>Robert U. Coale</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/31/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Manassas Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Manassas, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 1 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

VS A15 (4)  
15M 9/58

9335

CERTIFICATE OF DEATH

9335

*Robert W. Jones*

*Robert W. Jones*  
*Robert W. Jones*

*Robert W. Jones*  
*Robert W. Jones*

9357

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Colorado</b> b. COUNTY <b>Trinidad</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN TB <b>32 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Trinidad</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>1708 San Pedro Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Betty</b> Middle <b>Ann</b> Last <b>Sciaccia</b>			4. DATE OF DEATH Month <b>August</b> Day <b>2,</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1944</b>		9. AGE (In years last birthday) <b>15</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Colorado</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Lawrence Sciaccia</b>			14. MOTHER'S MAIDEN NAME <b>Sarafena Antista</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized hemorrhages</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute lymphocytic leukemia; severe pancytopenia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Trinidad</b>			20g. (County) <b>Colorado</b>		
21. I certify that I attended the deceased from <b>July 1</b> , 19 <b>59</b> , to <b>August 2</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 2</b> , 19 <b>59</b> , and that death occurred at <b>1:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/3/59</b> ACTUAL SIGNATURE <b>L. A. Gaydos</b> M.D. <b>The National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Lawrence A. Gaydos, M.D.</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL—CREMATION—REMOVAL (Specify) <b>removal</b>		22b. DATE THEREOF <b>8/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinidad, Colorado</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. Wash, D.C. N.W.;</b>			24a. REC'D BY REGISTRAR <b>AUG 4 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Ernest S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9224 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09324

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sen. and Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>1707 Rosmere Ave St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>Joseph</u> Last <u>Scott</u>				<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>10</u> Year <u>1959</u>															
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-5-45</u>		<b>9. AGE</b> (In years last birthday) <u>14</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>  </u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>							
<b>13. FATHER'S NAME</b> <u>Mr. Lewis &amp; Joseph Scott</u>								<b>14. MOTHER'S MAIDEN NAME</b> <u>Clara Mae Musketman</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>				<b>17. INFORMANT</b> <u>Mr. Lewis Scott, Father</u> Address <u>707 Rosmere Ave Silver Spring Md.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Cyphosium</u>  <u>929.8</u> <b>DUE TO</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  <b>(b)</b> <u>drowning</u>  <b>DUE TO</b>  <b>(c)</b> <u>  </u> </div> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u>																			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>  </u>																			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input checked="" type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming</u>															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>8-10</u> <u>PM</u> <u>1959</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>N.W. Branch</u>		<b>20f. (City or town)</b> <u>Silver Spring</u>		<b>(County)</b> <u>Montgomery</u>		<b>(State)</b> <u>MD</u>							
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <u>8-10-59</u>											
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BRUSCHERT</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>Aug 13 1959</u>				<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Lincoln Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Prince George County, Md</u>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walters, 254 Carroll St NW DC</u>								<b>ADDRESS</b> <u>  </u>				<b>24a. REC'D BY REGISTRAR</b> <u>  </u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			
<b>DATE</b> <u>AUG 13 '59</u>								<b>  </b>											

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100-333

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2224

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF DEATH: [illegible]  
5. PLACE OF DEATH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. MANNER OF DEATH: [illegible]  
9. SIGNATURE OF EXAMINER: [illegible]  
10. DATE: [illegible]



RECEIVED  
BALTIMORE  
MAY 10 1964

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10477

9358

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u> MARYLAND		STATE <u>md</u> COUNTY <u>Annamiddle</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn, md.</u>		CITY OR TOWN <u>Severn, md.</u> 02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Marilee Nursing Home 14511 Collesville Rd</u>		STREET ADDRESS (If rural give location) <u>14511 Collesville Rd, Silver Spring, md.</u>		DATE OF DEATH <u>Aug. 14</u> 19 <u>59</u>		DATE OF DEATH (Month) (Day) (Year)	
3. NAME OF DECEASED (Type or Print) <u>Reuben</u> (First) (Middle) (Last) <u>Shiftlett</u>		4. DATE OF DEATH <u>Aug. 14</u> 19 <u>59</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>		8. DATE OF BIRTH <u>Oct 27-1887</u> 9. AGE last birthday <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Jack Shiftlett - HARVEY Ave Severn, md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
422.1 IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized atherosclerosis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 11, 1955</u> , to <u>Aug 14, 1959</u> , that I last saw the deceased alive on <u>Aug 10, 1959</u> , and that death occurred at <u>10A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>1919 Semin Ave, Rt. 1, Silver Spring, Md.</u> DATE SIGNED <u>8-14-59</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>		DATE THEREOF <u>9.8.59</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's W.M. Schol</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur &amp; Frank</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>SEP 10 '59</u>				SEP 11 '59			



9225

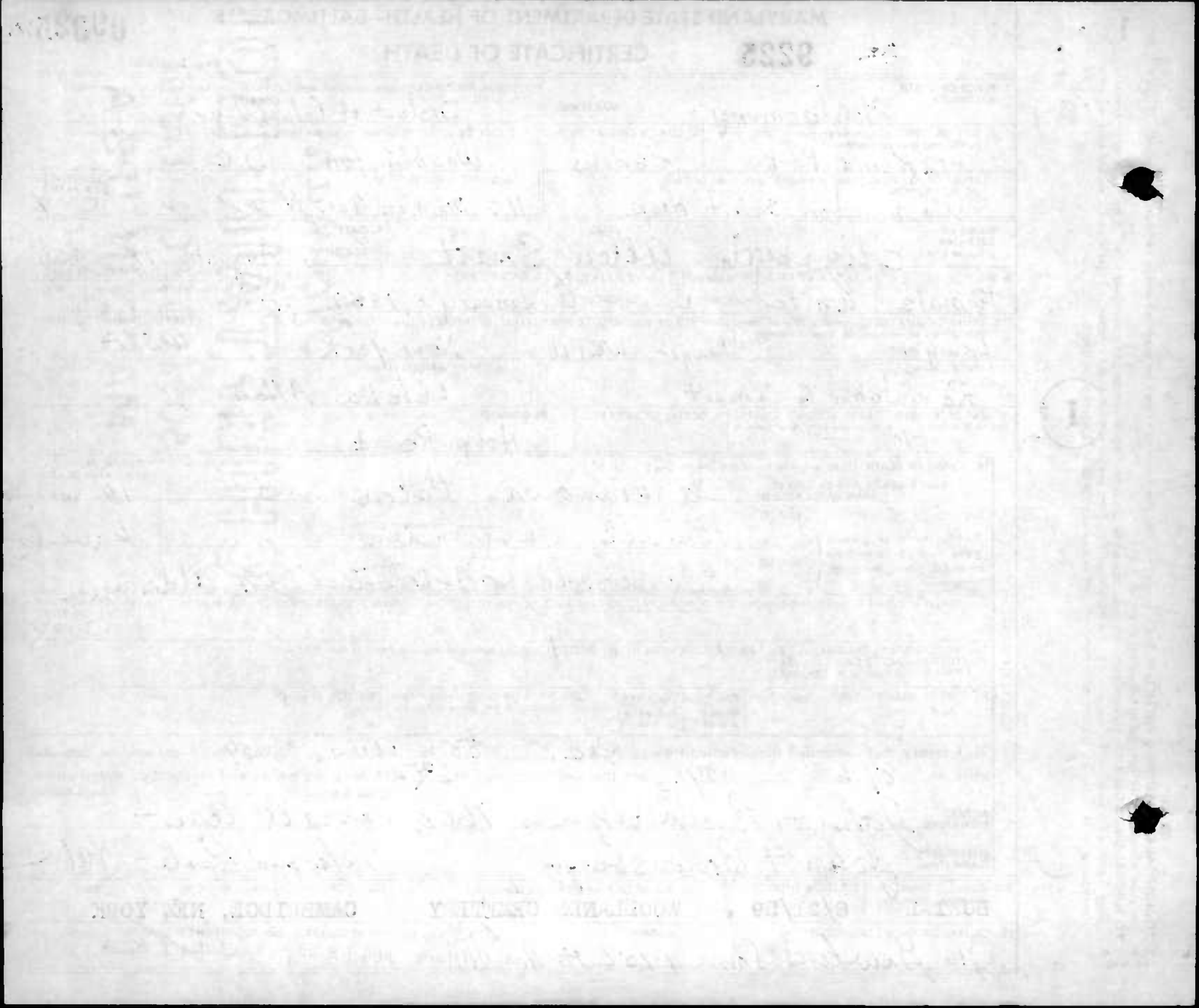
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>W</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>56 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanit Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Allen Smart</u>		4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 8, 1889</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>70</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer WETA</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. John G. Smart</u>		14. MOTHER'S MAIDEN NAME <u>Leleka Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hosp. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Colon and</u> <u>153.8</u> DUE TO <u>Bowel obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized Metastasis to Abdomen</u> (c) <u>Generalized Metastasis to Abdomen</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 mo,</u> <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153.8</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec.</u> , 1958, to <u>Aug.</u> , 1959 that I last saw the deceased alive on <u>8/16</u> , 1959, and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John F. Brownsberger</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave -</u>	
PHYSICIAN'S NAME (Type) <u>John F. Brownsberger</u>		DATE SIGNED <u>Takoma Park - Md -</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLANDS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE, NEW YORK</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Gawler's Sons</u>		ADDRESS <u>1752 Pa. Ave. NW</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

RECEIVED BY THE NEW YORK CITY DEPARTMENT OF HEALTH  
JANUARY 10 1910



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**9359**  
**CERTIFICATE OF DEATH**

09326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>California</b> b. COUNTY <b>Los Angeles</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN TB <b>94 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Monica</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1916</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Life Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Robert Smith</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Croak</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>396-18-5283</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Upper Gastrointestinal Hemorrhage</b> <b>159X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinomatosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Hemothorax</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>1 Year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> to <b>August 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 28</b> , 19 <b>59</b> , and that death occurred at <b>10:19P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>8/29/59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Jerry S. Triet</b> M.D. PHYSICIAN'S NAME (Type) <b>JERRY S. TRIET, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 8-30-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Little Wolf Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Waupaca County, Wisconsin.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Humphrey</b> ADDRESS <b>BETHESDA, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9360

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09327

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>56</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		d. STREET ADDRESS <b>10,121 KINROSS AVENUE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lois</b> Middle <b>M.</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>29</b> Year <b>19 59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/15/87</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b> Hours <b>4</b> Min.	11. IF UNDER 24 HRS. Months <b>2</b> Days <b>3</b> Hours <b>4</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Alexandria, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM ELLIS</b>		14. MOTHER'S MAIDEN NAME <b>LAURA SKILLMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mr. Norman S. Smith, 10,121 Kinross Ave.</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Hemorrhage (1 month)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5, 1959</b> to <b>Aug 29, 1959</b> that I last saw the deceased alive on <b>Aug 28, 1959</b> and that death occurred at <b>9:59 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b>		ADDRESS (Street, city or town, state) <b>9066 Calverville Rd Silver Spring Md</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM D. AUD</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/2/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		24. REC'D BY REGISTRAR DATE <b>SEP 2 '59</b>	
25. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

0332

2880

DEPARTMENT OF HEALTH

1

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "DEPARTMENT OF HEALTH" and "DEPARTMENT OF" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9361

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G246 8-18-59 et

CERTIFICATE OF DEATH

09328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>506 Crabb Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>May</b> Last <b>R. Snell</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/16/12</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Herndon, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank C. Samselle</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Bowie Oliver</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>578-20-1853</b>		17. INFORMANT <b>Husband (Same As Above)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330x Intracerebral Hemorrhage</b> DUE TO (b) <b>Ruptured Aneurysm, left Anterior Communicating</b> DUE TO (c) <b>5 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 5</b> , 19 <b>59</b> , to <b>Aug. 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug. 9</b> , 19 <b>59</b> , and that death occurred at <b>12:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Bowditch Hunter</b> M.D.		ADDRESS (Street, city or town, state) <b>809 Veins Mill Rd. Rockville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. Bowditch Hunter</b>		DATE SIGNED <b>8/10/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>		ADDRESS <b>5801, Cleveland Ave. Riverdale, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

00558



CERTIFICATE OF DEATH

13301





9362

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MONTGOMERY</u> b. COUNTY <u>WASHINGTON - D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>27 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON - D.C. 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>3708 BRANDYWINE ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>MONROE</u> Last <u>SPENCER</u>				4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-1895</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OMER R. SPENCER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZ. BEZNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1917-1920</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		INFORMANT <u>CHARLOTTE E. SPENCER</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, severe</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular-renal arteriosclerosis</u> DUE TO <u>5 yrs +</u> (c) <u>Hypertension, severe</u> DUE TO <u>5 yrs +</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Old left &amp; recent right hemiplegia 2) Nephrosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 16</u> , 19 <u>59</u> , to <u>Aug 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 16</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St.</u>		ADDRESS (Street, city or town, state) <u>Washington 15 DC</u>		DATE SIGNED <u>8/17/59</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Aug 18 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Christina S. Knaus</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

00832

I, the undersigned, being a duly qualified medical officer of health for the District of Columbia, do hereby certify that  
 the within and foregoing is a true and correct copy of the original record of the death of  
 the person named therein, as the same appears from the records of the Department of Health of the District of Columbia.  
 Witness my hand and the seal of the Department of Health of the District of Columbia, this 1st day of July, 1918.  
 J. H. HARRIS, M.D., Medical Officer of Health.  
 District of Columbia.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

9363

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09330

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>5yr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9815 Havemile Drive</u>				d. STREET ADDRESS <u>9815 Havemile Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>Mary</u> Last <u>Sperling</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Wm Springer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Overly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary Jane Warrick</u> Address <u>Stm 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschack</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschack</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-transit</u>		<u>8-23-59</u>		<u>Woodlawn Cemetery</u>		<u>Wilkinsburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

00000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2343

NAME OF DECEASED JAMES RAY		DATE OF DEATH JAN 13 1968	
PLACE OF DEATH JAMES RAY		DATE OF DEATH JAN 13 1968	
CAUSE OF DEATH HEART DISEASE		DATE OF DEATH JAN 13 1968	
MANNER OF DEATH NATURAL		DATE OF DEATH JAN 13 1968	
AGE 45		DATE OF DEATH JAN 13 1968	
SEX MALE		DATE OF DEATH JAN 13 1968	
RACE WHITE		DATE OF DEATH JAN 13 1968	
BIRTH DATE JAN 13 1923		DATE OF DEATH JAN 13 1968	
BIRTH PLACE BALTIMORE, MARYLAND		DATE OF DEATH JAN 13 1968	
EDUCATION HIGH SCHOOL		DATE OF DEATH JAN 13 1968	
OCCUPATION FARMER		DATE OF DEATH JAN 13 1968	
MARITAL STATUS MARRIED		DATE OF DEATH JAN 13 1968	
RELIGION METHODIST		DATE OF DEATH JAN 13 1968	
PREVIOUS ILLNESS HEART DISEASE		DATE OF DEATH JAN 13 1968	
TREATMENT NONE		DATE OF DEATH JAN 13 1968	
SIGNS AND SYMPTOMS HEART DISEASE		DATE OF DEATH JAN 13 1968	
POSTMORTEM EXAMINATION NONE		DATE OF DEATH JAN 13 1968	
FINDINGS HEART DISEASE		DATE OF DEATH JAN 13 1968	
REMARKS HEART DISEASE		DATE OF DEATH JAN 13 1968	
SIGNATURE JAMES RAY		DATE OF DEATH JAN 13 1968	
WITNESSES JAMES RAY		DATE OF DEATH JAN 13 1968	
CORONER JAMES RAY		DATE OF DEATH JAN 13 1968	
FILING OFFICE JAMES RAY		DATE OF DEATH JAN 13 1968	
FILING DATE JAN 13 1968		DATE OF DEATH JAN 13 1968	

1

NOV 1968

9364

CERTIFICATE OF DEATH

09331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>206 WHITESTONE ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>MARY</b> Last <b>STICKLER</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/69</b>
9. AGE (In years last birthday) <b>89</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JACOB STICKLER</b>		14. MOTHER'S MAIDEN NAME <b>AGATHA ROTH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>yes</b>	
17. INFORMANT <b>Mrs. Marie A. Preller, 206 Whitestone Road</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 wks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Aug 1</b> , 19 <b>59</b> , to <b>Aug 9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 9</b> , 19 <b>59</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>John W. Winkler Jr</b> M.D. <b>5800 10th Place Chillum Md 8/10/59</b> PHYSICIAN'S NAME (Type) <b>JOHN W. WINKLER, JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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9226

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>9 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6903 Laurel Ave</u>		e. STREET ADDRESS <u>515 Decatur St N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>William Henry Stith</u>		4. DATE OF DEATH <u>Aug 10 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 1909</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>store</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Stith</u>		14. MOTHER'S MAIDEN NAME <u>Etta Blunt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>225-36-0289</u>	
17. INFORMANT <u>John H. Pettit - 4x12 15th NW</u>		Address <u>John H. Pettit</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c) <u>stating the underlying cause last.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/14/59</u>		22b. DATE THEREOF <u>Aug 10 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shawshill Va</u>		22d. LOCATION (City, town, county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. N. Horton</u> ADDRESS <u>1322 U.S. St.</u>		24a. REC'D BY REGISTRAR <u>AUG 12 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9335

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	SEX <i>Male</i>	RACE <i>White</i>
DATE OF DEATH <i>Jan 15 1910</i>		TIME OF DEATH <i>10:30 AM</i>	PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>123 Main St. Baltimore, Md.</i>		OCCUPATION <i>Teacher</i>		
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		
SIGNATURE OF EXAMINER <i>John Doe</i>		SIGNATURE OF WITNESSES <i>John Doe</i>		
DATE OF EXAMINATION <i>Jan 15 1910</i>		PLACE OF EXAMINATION <i>Home</i>		
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF NEXT OF KIN <i>John Doe</i>		
SIGNATURE OF SURGEON <i>John Doe</i>		SIGNATURE OF JUDGE <i>John Doe</i>		
SIGNATURE OF CLERK <i>John Doe</i>		SIGNATURE OF NOTARY <i>John Doe</i>		



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>14604 Aspen Hill Rd S.S.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Edward</u> Last <u>Tataro</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 9 1939</u>		9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mr. Edward Tataro</u>				14. MOTHER'S MAIDEN NAME <u>Grace Tataro</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr. Edward Tataro</u> Address <u>4604 Aspen Hill Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> 825X DUE TO <u>Focal Cerebral Hemorrhage</u> 3hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>trauma Auto Accident</u> 3hrs (b) <u>  </u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Sternum, Internal Injuries</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury in auto involved in accident</u>		20c. TIME OF INJURY Month, Day, Year <u>2:10 p.m. 8-16 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Rockville Maryland</u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-16-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Wheaton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Lees - Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9366

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09334

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>83X-3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>3933 Usher Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Wade Hampton Taylor</b>		4. DATE OF DEATH Month Day Year <b>August 8, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1959</b>
9. AGE (In years last birthday) yrs. <b>3</b> Months <b>4</b> Days <b>4</b> Hours <b>Min.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lindsey H. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Helen West</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease</b> <b>7545</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 29, 1959</b> to <b>August 8, 1959</b> , that I last saw the deceased alive on <b>August 8, 1959</b> , and that death occurred at <b>4:00 A.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Vincent T. Andriole</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Vincent T. Andriole, M. D.</b>		DATE SIGNED <b>8-8-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 11, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Every Funeral Home; Fairfax, Virginia</b> By <b>Manager</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

9367

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 4, 22b Film 6246 8-24-59 et

Reg. Dist. No.

09335

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9941 Mayfield Drive</b>		d. STREET ADDRESS <b>9941 Mayfield Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>HUGH</b> Middle <b>R.</b> Last <b>THOMAS</b>		4. DATE OF DEATH <b>Aug</b> <b>May</b> <b>15</b> , <b>19</b> <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arthur W. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Alice Morton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wife</b>		Address <b>Eunice B. Thomas</b> <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>Aug. 15, 1959</b>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REBURY (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Fairfax, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		24a. REC'D BY REGISTRAR <b>AUG 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles J. King</b>			



9368

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>35 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>W</u> Last <u>Titus</u>				4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/17/07</u>	
9. AGE (In years lost birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>12</u> Hours <u>19</u> Min.		11. IF UNDER 24 HRS. Hours <u>19</u> Min.			
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gas Station Attendant</u>				10c. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Franklin Titus</u>				14. MOTHER'S MAIDEN NAME <u>Annie Frye</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>2102-07-9074</u>		INFORMANT <u>Sister (Mrs. Anna Brooks)</u> Address <u>Poolesville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Empyema</u> <u>518X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopulmonary Fungus</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>59</u> , to <u>Aug 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>59</u> , and that death occurred at <u>1012 AM</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>George William Ware</u> M.D. ADDRESS <u>900-176 St. H. W.</u> DATE SIGNED <u>8/14/59</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 15-59</u>		<u>Monocacy</u>		<u>Beallsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Hilton</u> ADDRESS <u>Baltimore, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

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CERTIFICATE OF DEATH

DEATH CERTIFICATE

CHIEF

WILLIAM J. HARRIS

DEATH

WILLIAM J. HARRIS

DEATH

WILLIAM J. HARRIS

DEATH

WILLIAM J. HARRIS

DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9369 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09337

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>8 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1016 Strout st</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>1016 Strout st</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>Chesley</u> Last <u>Trout</u>				<b>4. DATE OF DEATH</b> Month <u>Aug</u> Day <u>21</u> Year <u>1957</u>													
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-18-1880</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bakery</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pa</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. C.</u>									
<b>13. FATHER'S NAME</b> <u>Joseph Trout</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Amanda Grey</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Susie Trout</u> Address <u>Stm 2</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Hour _____ a. m. _____ p. m. Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>									
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>8-21-57</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>22b. DATE THEREOF</b> <u>8/24/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cem.</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Bladensburg Road, Maryland</u>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. H. Thompson</u> ADDRESS <u>5732</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Arthur S. Kline</u>		<b>24b. REGISTRAR'S SIGNATURE</b>											
<b>DATE</b> <u>AUG 26 '59</u>				<b>DATE</b>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# STATE DEPARTMENT OF HEALTH - BIRMINGHAM 19

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. TREATMENT	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	



9227

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>FLORIDA</u> b. COUNTY <u>St. Petersburg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u>			
c. LENGTH OF STAY IN 1b <u>45 min</u>				d. STREET ADDRESS <u>1054 55th Avenue N.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry Lloyd Tubman</u>				4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>m.</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-12-1883</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>Names.</u>		13. FATHER'S NAME <u>HARRY I. TUBMAN</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE A. SIMMONS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Hosp. records</u> Address <u>7600 Carroll Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> (c) <u>Coronary sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>(day)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/25, 1959</u> , to <u>8/25, 1959</u> , that I last saw the deceased alive on <u>8/25, 1959</u> , and that death occurred at <u>1030 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald Nelson</u>				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave Silver Spring, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCHESTER MEM. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC. Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9237

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. BOND		M		45		JAN 15 1892		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		BALTIMORE, MARYLAND	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
JAN 20 1937		10:15 AM		10		15		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF MINISTER	
J. H. BOND		J. H. BOND		J. H. BOND		J. H. BOND		J. H. BOND	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1937		JAN 20 1937		JAN 20 1937		JAN 20 1937		JAN 20 1937	

BOND

THE STATE OF MARYLAND, DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, JANUARY 20, 1937.

TO ALL WHOM THESE PRESENTS SHALL COME, I, JAMES H. BOND, DEPUTY COMMISSIONER OF HEALTH, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS THE SAME APPEARS IN THE RECORDS OF THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

9370

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09339

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5500 Newington Rd</u>		d. STREET ADDRESS <u>5500 Newington Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HAROLD</u> Middle <u>G.</u> Last <u>TUFTY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jonas O. M. Tufty</u>		14. MOTHER'S MAIDEN NAME <u>Teena Wigsdal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>358-01-4964</u>	
17. INFORMANT <u>Edith H. Tufty-wife-same as 2d</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dr. Broochart notified and released</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1958</u> , to <u>Present</u> , that I last saw the deceased alive on <u>8/28</u> , 19 <u>59</u> , and that death occurred at <u>undetermined</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. DuChes</u> M.D.		ADDRESS (Street, city or town, state) <u>5500 Newington Rd Bethesda, Md.</u> DATE SIGNED <u>8/29/59</u>	
PHYSICIAN'S NAME (Type) <u>John W. DuChes</u>		2015 Wash. 9, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>9/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Deluth, Minnesota</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

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TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09340	
9371										CERTIFICATE OF DEATH	
Reg. Dist. No. 215											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>					b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. LENGTH OF STAY IN 1b <b>1 hr. 40 min.</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>2474 Alabama Ave., S. E.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <b>(Twin "A")</b>			Middle <b>WADE</b>			4. DATE OF DEATH Month <b>August</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>Negro</b>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>8-15-59</b>		
9. AGE (In years last birthday) <b>1</b>			10. AGE (In years last birthday) <b>40</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>					11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Wallace R. WADE</b>					14. MOTHER'S MAIDEN NAME <b>Eileen V. VINCENT</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>NO</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>(F) W. R. Wade, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity with immaturity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Bethesda</b>					20g. (County) <b>Montgomery</b>					20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>August 15</b> , 19 <b>59</b> , to <b>August 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>12:05 A.M.</b> , from the causes and on the date stated above.										DATE SIGNED <b>8-17-59</b>	
ACTUAL SIGNATURE <i>[Signature]</i>					ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b>						
PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b>					Bethesda 14, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>8-19-59</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) <b>Arlington</b>					22e. (State) <b>Virginia</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>					ADDRESS <b>W. E. Jarvis Funeral Home, 1432 U St. NW, Wash. DC</b>					24a. REC'D BY REGISTRAR <b>AUG 19 '59</b>	
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

2151163XV0

# CERTIFICATE OF DEATH

2811

1. Name of deceased

2. Sex (Male or Female)

3. Date of birth

4. Place of birth

5. Date of death

6. Cause of death

7. Date of death

8. Place of death

9. Date of death

10. Date of death

11. Name of physician

12. Name of physician

13. Name of physician

14. Name of physician

15. Name of physician

16. Name of physician

17. Name of physician

18. Name of physician

19. Name of physician

20. Name of physician

21. Name of physician

22. Name of physician

23. Name of physician

24. Name of physician

25. Name of physician

26. Name of physician

27. Name of physician

28. Name of physician

29. Name of physician

30. Name of physician

31. Name of physician

32. Name of physician



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09341

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>4 hrs. 48 min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2474 Alabama Ave., S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>(Twin "B") WADE</b>		4. DATE OF DEATH Month Day Year <b>August 16 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-15-59</b>
9. AGE (In years lost birthday) yrs. Months Days <b>4 48</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wallace R. WADE</b>		14. MOTHER'S MAIDEN NAME <b>Eileen V. VINCENT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>(F) W. R. Wade, same as #2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity with immaturity</b> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 15</b> , 19 <b>59</b> , to <b>August 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 16</b> , 19 <b>59</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-17-59</b> ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>U. S. Naval Hospital</b> PHYSICIAN'S NAME (Type) <b>F. DE PAOLA, LCDR, MC, USN</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-19-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Jarvis Funeral Home</b> ADDRESS <b>W.E. Jarvis Funeral Home, 1432 U St. NW, Wash. DC</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2251164XV0

CERTIFICATE OF DEATH

State of Colorado

County of Adams

City of Denver

(Date)

8-22-22

Deceased

Elmer V. VICKER

(V) M. E. Vicker, born at above

Presumably with family

8-22-22

U. S. Health Registrar

Residence at death

Witness

Attorney

Religious Minister

U. S. Health Registrar, with

9234

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN 1b <b>26</b> <b>ROCKVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>230 FALLS ROAD</b>		1 d. STREET ADDRESS <b>230 FALLS ROAD</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HATTIE L. WARD</b>		4. DATE OF DEATH <b>August 9, 1959</b> 19 <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1867</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>George M. Fry</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Stout</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Norman E. Ward</b>		127 S. Adams Street <b>Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis</b> DUE TO (c) <b>generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>48 hrs</b> <b>Tridly.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Bronchopneumonia</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/1, 1959</b> to <b>8/9, 1959</b> , that I last saw the deceased alive on <b>8/9, 1959</b> , and that death occurred at <b>11:55 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>8/10/59</b>	
PHYSICIAN'S NAME (Type) <b>Stephen Jones - Rockville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		ADDRESS <b>Rockville, Maryland</b>	
24a. REC'D BY REGISTRAR <b>AUG 12 59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles A. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9373

CERTIFICATE OF DEATH

09343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	c. LENGTH OF STAY IN 1b <b>2 mos. 20 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. STREET ADDRESS <b>3902 Knowles Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Marjorie</b> Middle <b>C.</b> Last <b>Warren</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/93</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>John Ingram</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>Alexandria, Va.</b> <b>Ruby C. Conner 15 W. Groves Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia and Shock</b> <b>199.2</b> DUE TO <b>Internal haemorrhage (gastro-intestinal, uterine)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Obtundition jaundice</b> DUE TO (c) <b>Generalized Carcinomatosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 1</b> , 19 <b>59</b> , to <b>Aug 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Aug 10</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>26-N. SUMMIT AVE 10424 1959</b> DATE SIGNED <b>GAITHERSBURY, MD</b>			
ACTUAL SIGNATURE <b>Gordon Rosenberg</b> M.D.		PHYSICIAN'S NAME (Type) <b>Gordon Rosenberg</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Aug. 11, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>The S. H. Hines Co. 2901-14-St. NW</b>		22d. LOCATION (City, town, or county) (State) <b>Danville, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. 2901-14-St. NW</b>		24a. REC'D BY REGISTRAR <b>AUG 12 '59</b>	
ADDRESS <b>Wash, DC</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

2373



*[Faint, mostly illegible handwritten text on a form with multiple sections and lines.]*





9374

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09344

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>565 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Washington</u> Last <u>Washington</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/16/08</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Marshall Washington</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>		INFORMANT <u>Gertrude Washington, Stewards Lane</u>		Address <u>Silver Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>CORONARY OCCLUSION</u> (c) <u>CORONARY ARTERIOSCLEROTIC HEART DISEASE UNDETERMINED</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS</u> <u>6 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/23/59</u> , 19 <u>59</u> , to <u>SAME</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>8/23/59</u> , 19 <u>59</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Dohy</u>		M.D. <u>7720 WILSON AVE BETHESDA, MD.</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>8/23/59</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-27-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope Church</u>		22d. LOCATION (City, town, or county) (State) <u>COLESVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. E. J. Jannis</u>		ADDRESS <u>Co. 1432 - you H.W.</u>		24a. REC'D BY REGISTRAR <u>AUG 26 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

C.H.S.

ACUTE MYOCARDIAL INFARCTION

C.H.S.

CONGENITAL CORONARY OCCLUSION

CONGENITAL ARTERIOVENOUS HEART DISEASE

X

2/25/52  
2/25/52

8/23/52

2/25

2/25/52

John H. Murphy

BETHESDA, MD.  
1120 WISCONSIN AVE.

2/25/52

9375

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>XXXXX</u> Last <u>Weiger</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1900</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>27</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>labor</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MARDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-03-2441</u>			
17. INFORMANT <u>Mrs. Ida B. Weiger</u> Address <u>Same as #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> (b) <u>Cirrhosis of Liver</u> (c) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March</u> , 1958, to <u>2 Aug</u> , 1959, that I last saw the deceased alive on <u>2 Aug</u> , 1959, and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.S. Murphy</u>				ADDRESS (Street, city or town, state) <u>605 W. Montgomery Ave. Rockville, Md.</u> DATE SIGNED <u>3 Aug 59</u>			
PHYSICIAN'S NAME (Type) <u>William S. Murphy</u>				<u>615 W. Montgomery Ave., Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>Aug 4 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

3872

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

Local Hospital

Local Physician

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 09346									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D C</b> b. COUNTY <b>✓</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery County General Hospital</b>					d. STREET ADDRESS <b>477 M Street, N. W.</b>				
3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>NMN</b> Last <b>Wesley</b>					4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>19 59</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/25/1892</b>		9. AGE (In years last birthday) <b>67 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Rubin Wesley</b>					14. MOTHER'S MAIDEN NAME <b>Camilla McCullum</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Alione Groves</b> Address <b>206 P St., N.W., Washington, D.C.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collapsed while laying brick and fell 4 ft from scaffold</b> 20c. TIME OF INJURY Month, Day, Year <b>8 17 19 59</b> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glenmont S. Cntr. Wheaton Montg. Md.</b> 20f. (City or town) (County) (State) <b>Id</b> 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>8.17.59</b>				
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M. D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-22-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Malvan &amp; Schey, Inc. 424 "R" St., N. W.</b> ADDRESS <b>Wash., 1, D.C.</b>					24a. REC'D BY REGISTRAR <b>ANG 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>		







TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)  
15M 9/58

Deputy Medical Examiner, Montgomery Co., notified.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
9377											
CERTIFICATE OF DEATH											
Reg. Dist. No. 215											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>132 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>48 X 3</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Petersburg</b> d. STREET ADDRESS <b>5121 5th Ave. N.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Lois</b> Middle <b>Fey</b> Last <b>WHITE</b>			4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>19 59</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-2-07</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>52</b> Days <b>52</b> Hours <b>52</b> Min. <b>52</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Edward FEY</b>					14. MOTHER'S MAIDEN NAME <b>Eva GANT</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>220-26-4746</b>		INFORMANT <b>(H) John P. White, same as #2 above</b> Address						
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Surgical shock</b> 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Laminectomy for cord stony.</b> DUE TO (b) <b>Carcinoma, squamous, rectum</b> DUE TO (c) <b>6 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>24 hours</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>April 7</b> , 19 <b>59</b> , to <b>August 17</b> , 19 <b>59</b> that I last saw the deceased alive on <b>August 17</b> , 19 <b>59</b> , and that death occurred at <b>11:25A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>8-17-59</b>											
ACTUAL SIGNATURE <b>W. H. Druckemiller</b> M.D. <b>U. S. Naval Hospital</b> PHYSICIAN'S NAME (Type) <b>W. H. DRUCKEMILLER, CAPT, MC, USN</b> <b>Bethesda, Maryland</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chevy Chase Funeral Home, 5103 Wisc. Ave. NW, WDC</b>					24a. REC'D BY REGISTRAR <b>AUG 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>				

*Chevy Chase Funeral Home*

9373

CERTIFICATE OF DEATH

MINI  
MAY 19 1964

0-1-64  
9373

Decedent (Name) \_\_\_\_\_  
U. S. Social Security Number \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_  
Marital Status \_\_\_\_\_  
Usual Residence \_\_\_\_\_  
Place of Birth \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Time of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_  
Signature of Physician \_\_\_\_\_  
Signature of Registrar \_\_\_\_\_  
Date of Registration \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
County \_\_\_\_\_

U. S. Social Security Administration  
Washington, D. C. 20535  
Form 100-10 (Rev. 1-64)  
This certificate is to be filled out by the physician or other qualified person who has attended the decedent during the last illness and who has witnessed the death.  
It should be filled out as soon as possible after death, and should be filed with the local health department or the state health department.  
A copy of this certificate should be sent to the family of the decedent, and a copy should be kept by the physician or other qualified person who has attended the decedent during the last illness.

9228

**CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN lb <u>31 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington San &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Belle</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-25-74</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>31</u> Hours <u>19</u> Min.		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>			
13. FATHER'S NAME <u>David Reel</u>				14. MOTHER'S MAIDEN NAME <u>Emma McKee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerosis of coronary also</u> (c) <u>Pseudo-bulbar palsy due to basilar artery thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>sub</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 16</u> , 19 <u>59</u> to <u>Aug 31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 30 (30)</u> , 19 <u>59</u> , and that death occurred at <u>3:35</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H. Wolohon, MD</u>				DATE SIGNED <u>Chas H. Wolohon</u>			
PHYSICIAN'S NAME (Type) <u>Chas H. Wolohon</u>				<u>7600 Carroll Ave</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>Sept. 3, 1959</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Chesapeake</u> <u>Ohio</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>				24a. REC'D BY REGISTRAR <u>SEP 1 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>							

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECORDED

CERTIFICATE OF DEATH

8338

Charles W. Wood

*[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]*

Charles W. Wood  
The above-named  
Charles W. Wood

9378

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Kensington Gardens Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington, Virginia</b> d. STREET ADDRESS <b>4507 No. Washington Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry F Williams</b> First Middle Last		4. DATE OF DEATH <b>August 25</b> Month Day Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5 1881</b> yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telegraph Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Communication</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Albert Williams</b>		14. MOTHER'S MAIDEN NAME <b>Laura Virginia Welch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-01-6709</b> INFORMANT <b>Lida E Williams</b> Address <b>4507 - N Washington Blvd. VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism, Massive</b> <b>463X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Phlebitis Right Leg</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 14 19 59</b> to <b>Aug 25 19 59</b> , that I last saw the deceased alive on <b>August 24 19 59</b> , and that death occurred at <b>7:20a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert T. Thibadeau</b>		ADDRESS (Street, city or town, state) <b>10609 Concord Street</b> DATE SIGNED <b>August 25, 1959</b>	
PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		<b>Kensington, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/28/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert T. Thibadeau</b> ADDRESS <b>Arlington, Va.</b>		24a. REC'D BY REGISTRAR <b>Aug 27 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hanna</b>			

1 X

Page 4

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

0378

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

DATE OF DEATH

PLACE OF DEATH

U.S. MAR. 2, 1914

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH



Reg. Dist. No. 215

**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution had residence before admission) a. STATE <b>N.H.</b>		b. COUNTY <b>Hillsboro</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN IB <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester</b>		<b>66 X - 3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda Md.</b>				d. STREET ADDRESS <b>68 Appleton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>Frederick</b>		Middle <b>WILLIAMS</b>		Last	
4. DATE OF DEATH <b>August</b>		Month <b>2</b>		Day <b>19</b>		Year <b>59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-39</b>	
9. AGE (In years last birthday) <b>20</b>		yrs.		IF UNDER 1 YEAR Months <b>2</b>		IF UNDER 24 HRS. Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman apprentice</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>N.H.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick A. WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>Mildred (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>003-26-2976</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lower nephron nephrosis and uremia</b> <b>857X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple crushing injuries and amputations, traumatic</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>		11 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was crushed between ship and dock at N. Rec. Lab. DC</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>7-22-59</b> p. m.		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>N. Rec. Lab. DC</b>		20f. (City or town) (County) (State) <b>Washington D.C.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-3-59</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>8-3-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manchester</b>		22d. LOCATION (City, town, or county) (State) <b>New Hampshire</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		ADDRESS <b>Wash, D. C.</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	
<b>W.W. Chambers Funeral Home, 1400 Chapin St. NW</b>							



9380

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> d. STREET ADDRESS <b>337 Chinlee Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Thomas</b> Last <b>WILLIS, JR.</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-30-59</b>
9. AGE (In years lost birthday) yrs. <b>6</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. <b>6</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John T. WILLIS</b>		14. MOTHER'S MAIDEN NAME <b>Mary PULLIAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>prematurity (32 wks)</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 30</b> , 19 <b>59</b> , to <b>August 5</b> , 19 <b>59</b> , that I lost the deceased alive on <b>August 5</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>8-6-59</b>			
ACTUAL SIGNATURE <b>G. B. Avery</b>		M.D. <b>U. S. Naval Hospital</b>	
PHYSICIAN'S NAME (Type) <b>G. B. AVERY, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-10-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b> ADDRESS <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 10 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

0880

Deceased (Name)

Deceased (Address)

U.S. Naval Hospital

U.S. Naval Hospital

John

John

1-30-39

1-30-39

Deceased

Deceased

Deceased

Deceased

Deceased

Deceased

*Deceased*

U.S. Naval Hospital

U.S. Naval Hospital

1-30-39

1-30-39

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

9381

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>12 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Chevy Chase</b> d. STREET ADDRESS <b>105 Hesketh Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Brent YOUNG</b>		4. DATE OF DEATH Month Day Year <b>August 15 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-18-88</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William B. YOUNG</b>	
14. MOTHER'S MAIDEN NAME <b>Alice C. JONES</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>WWI &amp; WWII</b>		17. INFORMANT <b>Robt. L. Young, 4213 Rosedale Ave., Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive coronary occlusion, posterior infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive cardio-vascular disease</b> c) <b>lying cause lost.</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 3</b> , 19 <b>59</b> , to <b>August 15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>August 15</b> , 19 <b>59</b> , and that death occurred at <b>9:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital</b> <b>8-15-59</b>			
ACTUAL SIGNATURE <b>C. W. BRAMLETT, LT, MC, USN</b>		M.D. <b>Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawley's &amp; Sons, 1756 Penn. Ave., NW, Wash. DC</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

VS A15 (4)  
15M 9/58

12887

U. S. Navy Hospital

Robertson (Mrs.)

12 days

Obituary notice

U. S. Naval Hospital

105th Hospital

Albany

State

YOUTH

1914-15

Continued

IX

8-18-35

U. S. Navy

Washington, D. C.

William H. Young

Miss E. Young

Miss A. Will

Robert L. Young, 2215 Broadway Ave., New York, N. Y.

Investigative company, New York, N. Y.

Investigative company, New York, N. Y.

August 28

August 1

August 12

U. S. Naval Hospital

Robertson, Mrs. Wm.

Albany, New York

8-17-35

Albany, New York

1100 Main Ave., New York, N. Y.